
The Economic Costs of Substance Abuse

**Economic
Costs**



United States

Washington

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The Economic Costs of Substance Abuse in the United States

A study sponsored by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism estimated the total economic costs of alcohol and drug abuse in the United States at more than \$276 billion in 1995.¹

Among the study's key findings were:

- *Alcohol abuse accounted for 60% of the total economic costs; 40% were attributable to drug abuse.*
- *More than 132,000 deaths were attributable to substance abuse.*
- *Lost earnings due to premature death, illness, disability, crime, and victimization constituted 71% of the total costs.*
- *Total medical costs related to alcohol and drug abuse (\$22.5 billion) were approximately double the amount spent on treatment (\$11.9 billion).*
- *Medical costs related to alcohol abuse (\$15.8 billion) were almost two-and-a-half times those for drug abuse (\$6.6 billion).*
- *Less than 4.3% of total economic costs were for treatment.*

A 2000 study found that, of the more than \$1.05 trillion spent on health care in the United States in 1997, less than 1% (\$11.4 billion) went for substance abuse treatment.²

¹ Harwood, H., et al. *The Economic Costs of Alcohol and Drug Abuse in the United States – 1995*, Table 1.4. Bethesda, MD: U.S. Department of Health and Human Services, 1998.

² Coffey, R., et al. *National Expenditures for Mental Health and Substance Abuse Treatment, 1997*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment and Center for Mental Health Services, 2000.

The Economic Costs of Substance Abuse

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The Economic Costs of Substance Abuse in the Washington State

A study sponsored by the Division of Alcohol and Substance Abuse estimated the total economic costs of alcohol and drug abuse in Washington State at \$2.54 billion in 1996.¹ This represents approximately \$531 for every non-institutionalized resident in the state.

Among the study's key findings were:

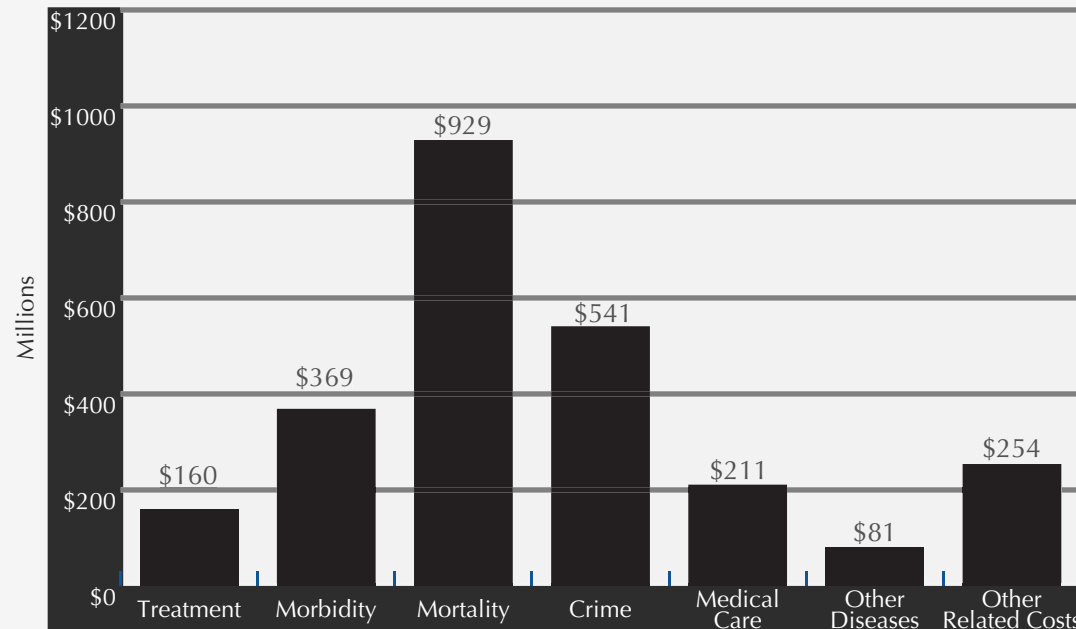
- *59% of the economic costs were attributable to the use of alcohol; 41% to the use of drugs.*
- *There were 2,824 deaths in 1996 caused by or related to alcohol or drug abuse, representing approximately 70,000 potential life-years lost.*
- *Of the 2,824 deaths, 2,318 were alcohol-related, and 506 were drug-related.*
- *Leading causes of substance abuse-related deaths were motor vehicle accidents (353 deaths), alcohol cirrhosis (291 deaths), and suicide (223 deaths).*
- *Of 217 arrests for homicide, 65 were alcohol-related, and 22 were drug-related.*
- *Of 6,003 arrests for felonious assault, 1,801 were alcohol-related, and 144 were drug-related.*
- *There were 16,000 hospital discharges classified as alcohol- or drug-related.*
- *Total estimated alcohol- and drug-related crime costs in 1996 rose to \$541 million from \$348 million in 1990, representing a 55% increase.*

¹ Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Costs Related to Mortality, Crime, and Morbidity Represent the Largest Economic Costs of Drug and Alcohol Abuse.



Economic Costs of Drug and Alcohol Abuse in Washington, 1996



Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Washington State Division of Alcohol and Substance Abuse, 1999.

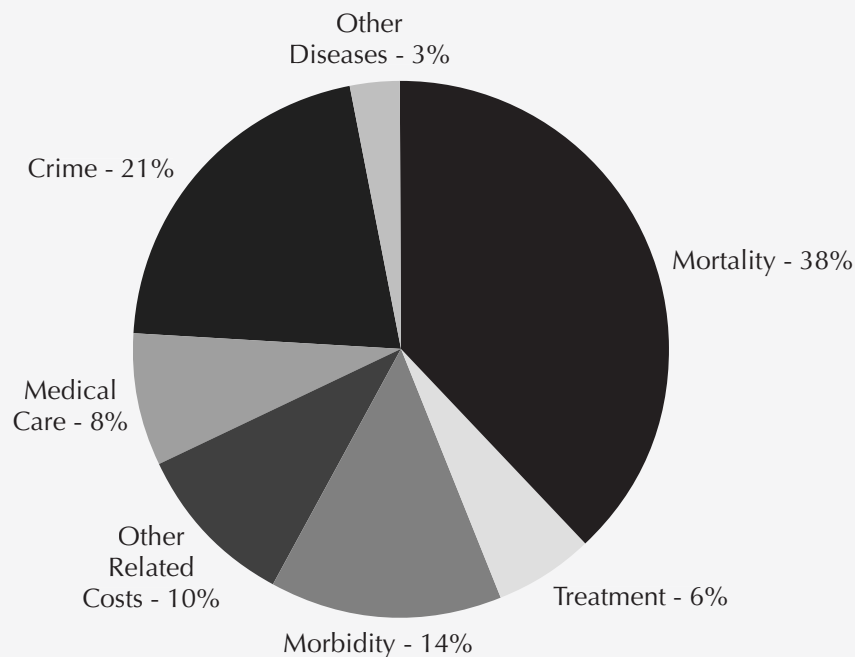
This graph indicates that mortality-, crime-, and morbidity-related costs represented the largest economic costs of substance abuse in 1996. The estimated cost per death measured in terms of lost income was \$329,000.¹ Adult and juvenile arrests for drug offenses in Washington State increased 287% from State Fiscal Years 1985 to 2002, while adult felony superior court filings for drug offenses increased by 406% in the same period.

¹ Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.



Treatment Represented Only 6% of the Total Economic Costs of Alcohol and Drug Abuse in 1996.

Distribution of Drug and Alcohol Costs



Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

This chart indicates that alcohol and drug treatment represents a very small fraction of the total economic costs of substance abuse in Washington State.¹ Yet, data — much of which is contained in this report — indicate that treatment can contribute significantly to lower morbidity and mortality, decreased crime, increased employment and higher worker productivity, reduced spread of infectious diseases, and lower medical costs. Alcohol and drug treatment continue to be wise investments in the health and safety of communities, and the economic vitality of Washington State.

¹ Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Impacts of Substance Abuse on the Washington State Budget



A 2001 study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated 1998 state government spending on the consequences of substance abuse in Washington State at \$1.5 billion. Only 4% of that total was spent on prevention and treatment.¹

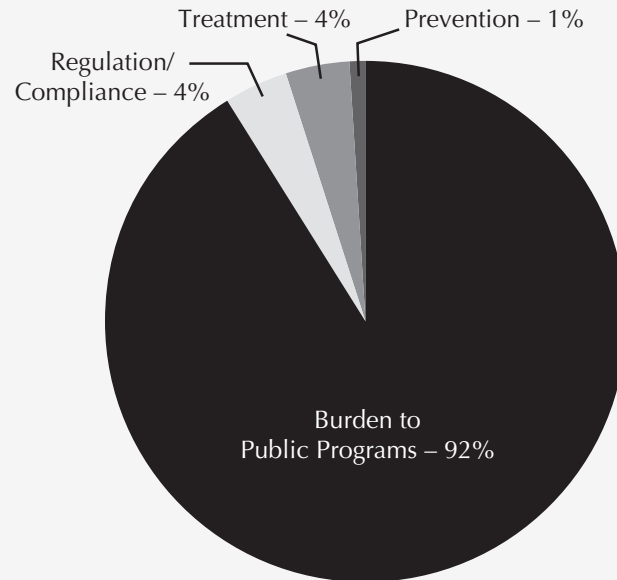
Other key findings of the study included:

- *Nationally, of a total of \$620 billion in state government spending, \$81.3 billion (13.1%) was used to deal with substance abuse and addiction.*
- *Of every such dollar spent by states, 96 cents went to “shoveling up the wreckage of substance abuse and addiction”; only four cents was used to prevent and treat it.*
- *Combined, states spent 113 times as much to deal with the devastation substance abuse and addiction wrought upon children as they did to prevent and treat it.*
- *Of the \$25 billion spent on dealing with the impacts of substance abuse on children, \$16.5 billion was borne by the public education system; another \$5.3 billion was spent on services for children who were victims of substance abuse and neglect; and almost \$3 billion was spent serving substance-involved youth in states’ juvenile justice systems.*
- *Each American paid \$277 per year in state taxes to deal with the burden of substance abuse and addiction within social programs, and only \$10 for prevention and treatment.*



Of the \$13.9 Billion in Washington State Government Spending in 1998, \$1.5 Billion (10.9%) was Spent on Services Related to Impacts of Substance Abuse.

***Distribution of State Spending
Related to Impacts of Substance Abuse***

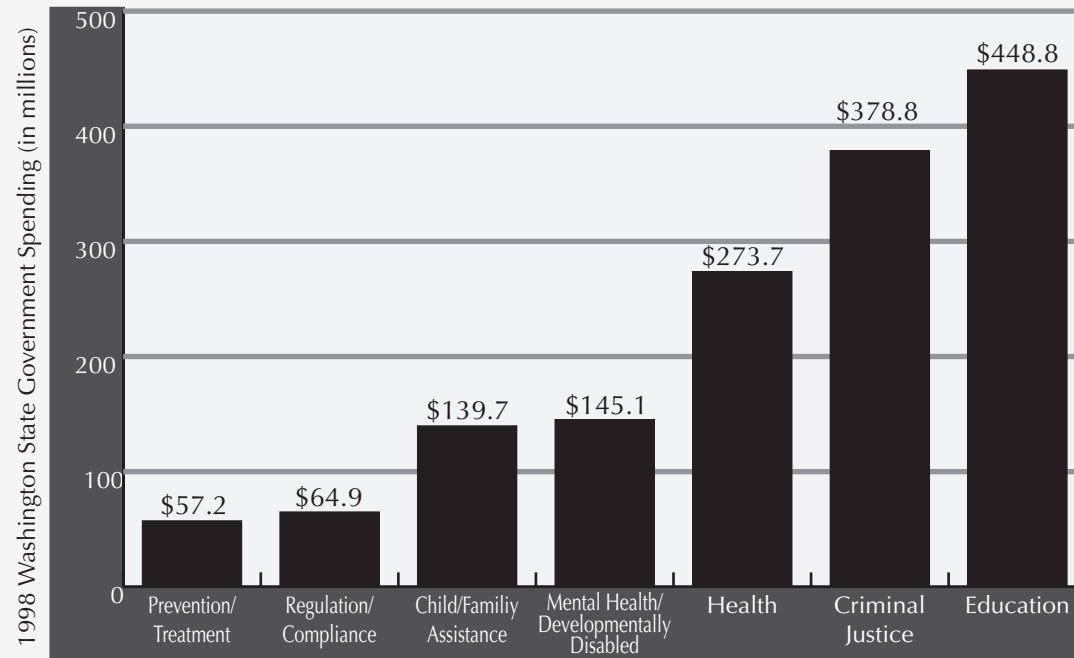


Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, 2001.

In 1998, the \$1.51 billion of Washington State government spending related to the impacts of substance abuse compares with \$2.65 billion spent on higher education, \$1.46 billion spent on Medicaid, and \$1.09 billion spent on transportation.¹

¹ National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*. New York, NY: 2001.

Substance Abuse Results in Significantly Higher State Government Spending on Education, Criminal Justice, and Health.



Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, 2001.

In 1998, 10% of Washington State government spending, or \$248 for every resident, was related to impacts of substance abuse. Only approximately \$10 of this amount went for prevention and treatment.¹

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE



Adolescent
Substance
Use and Beliefs

Adult
Substance
Use

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE



Adolescent
Substance Use
and Beliefs

Adult
Substance
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Washington's "Healthy Youth Survey"

In Washington State, there have been efforts to conduct surveys of youth health behavior since 1988. The surveys have been based on two different national surveys: Monitoring the Future supported by the National Institute on Drug Abuse; and the federal Centers for Disease Control and Prevention's Youth Risk Behavior Survey. In 1995, a Communities That Care survey, developed by the University of Washington, became an important component of the survey effort, integrating risk and protective factors. More recently, a Youth Tobacco Survey was incorporated.

To better coordinate these survey efforts, and to prevent the need for survey data from becoming an undue burden on schools, interested state agencies - Office of Superintendent of Public Instruction; Department of Social and Health Services' Division of Alcohol and Substance Abuse; Department of Health's Tobacco Control Program and Maternal and Child Health Program; Department of Community, Trade & Economic Development, Community Mobilization; and the Family Policy Council - resolved to cooperate on the administration of a single survey of youth behaviors every two years.

The goals of this collaborative effort are:

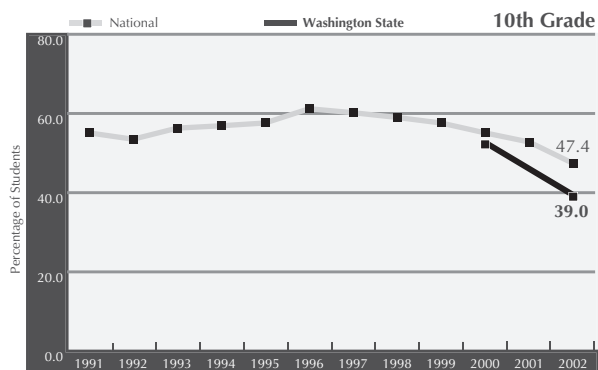
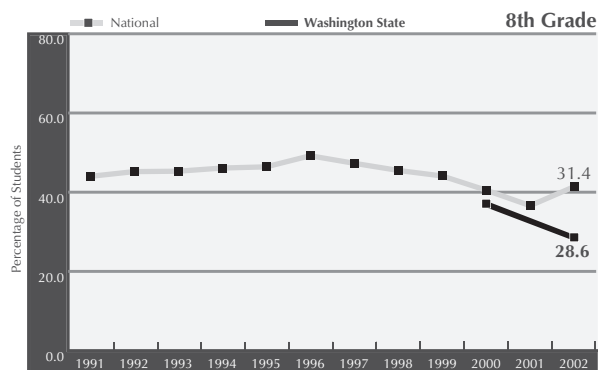
- To describe youth health behavior, habits, risks, and outcomes; and
- To describe school, community, family, and peer-individual risk and protective factors.

To achieve these goals, it was agreed that the survey must:

- Gather state-level data in a consistent manner (with predictable timing and using comparable measures over time); and
- Support local-level data collection and use for planning, assessment, and evaluation.

The data presented on the following pages are from the Washington State Survey of Adolescent Behaviors, which, beginning in 2002, represents the result of these collaborative efforts.

The Percentage of Students, Both in Washington and Nationally, Who Have Ever Smoked a Cigarette is Declining.*



Tobacco use is the leading cause of preventable illness and death in the United States.¹ A 1996 federal Centers for Disease Control and Prevention study suggests that 33% of young smokers will eventually die as a result of tobacco use, if current use patterns continue.²

These graphs indicate that experimentation with tobacco is on the decline, both in Washington State and nationally. *Healthy People 2010* sets a target objective to increase the average age of adolescents' first use of tobacco products from 12 to 14.

¹ U.S. Surgeon General, *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

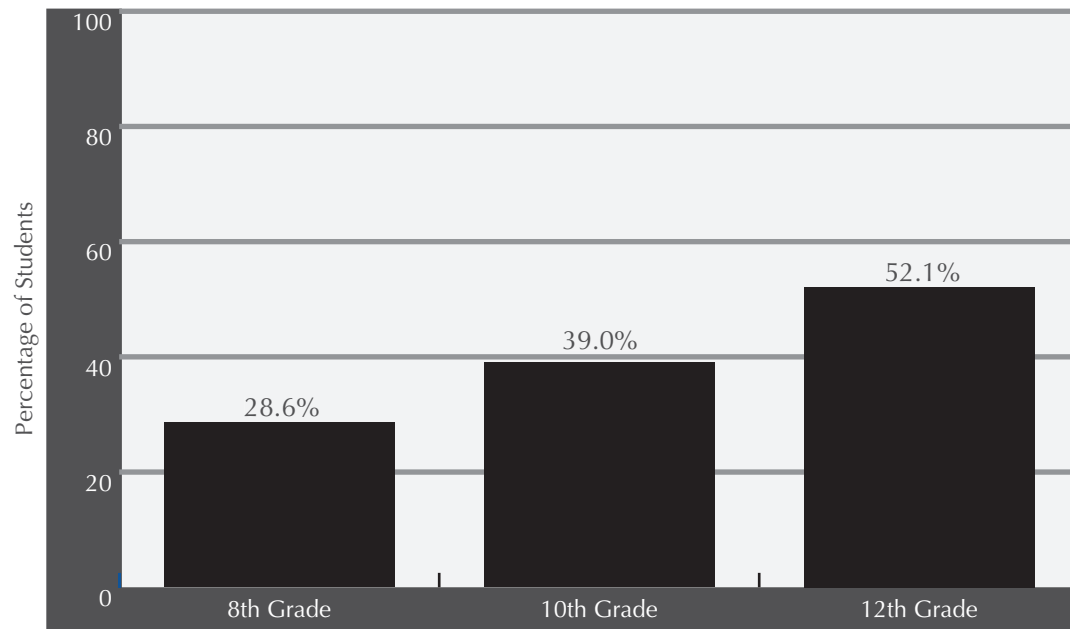
² Centers for Disease Control and Prevention. "Projected Smoking-Related Deaths Among Youth – United States," *Morbidity and Mortality Weekly Report* 45:971-974, 1999.

*The Washington State Survey of Adolescent Health Behaviors (WSSAHB) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between WSSAHB and MTF thus should not be made, except for the purpose of viewing trends.

Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.



By 12th Grade, More Than Half of Washington Adolescents Have Tried Smoking.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2002*.

The percentage of Washington State students who have experimented with smoking is declining. Experimentation and use of smokeless tobacco among students is also on the decline.¹

Healthy People 2010 notes that data from community research studies and other evidence indicates that increasing excise taxes on cigarettes, when combined with smoking campaigns, is one of the most cost-effective short-term strategies to prevent tobacco initiation among youth.² A recent study found that 70% of U.S. youths ages 14-17 report they can purchase cigarettes within five blocks of their home.³ However, a study of middle school youth in Texas indicated that these youth obtained cigarettes by purchasing them only 7% of the time. Some 57% obtained them from someone else; 36% stole them or obtained them in some other way.⁴

¹ Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2002*.

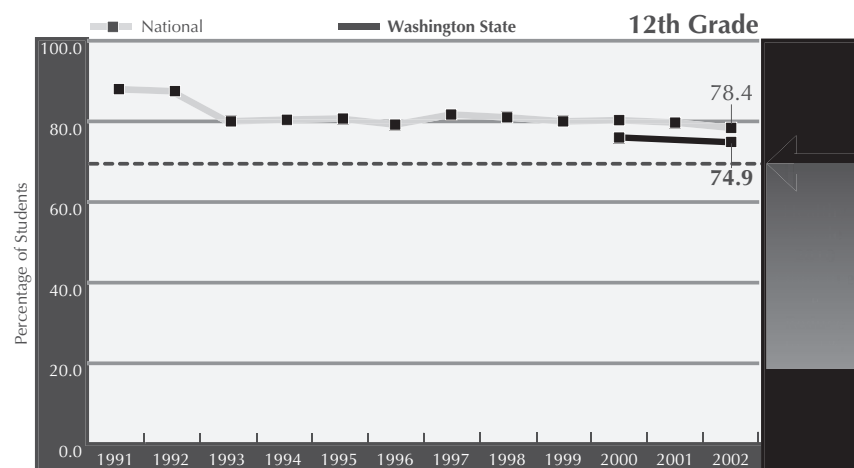
² U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 27-6. Washington, DC: 2000.

³ Institute for Adolescent Risk Communication, *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.

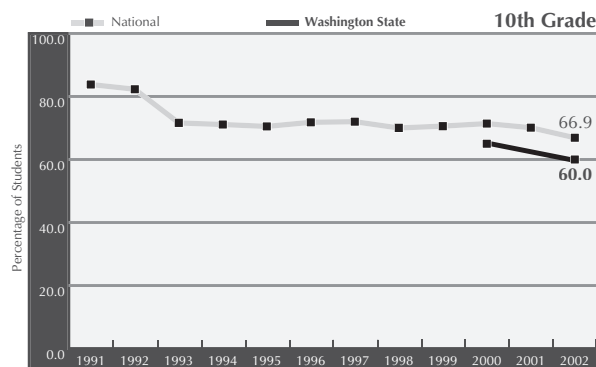
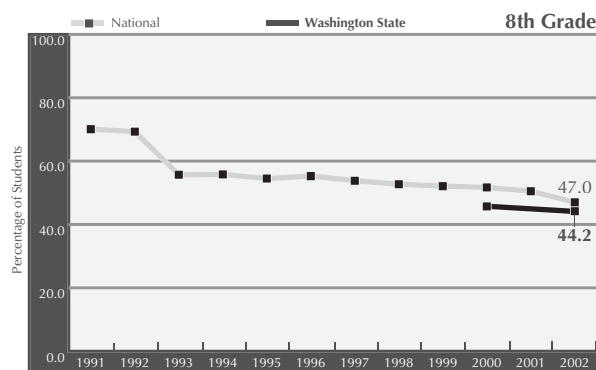
⁴ Centers for Disease Control and Prevention, "Usual Sources of Cigarettes for Middle and High School Students – Texas, 1998-1999," *Morbidity and Mortality Weekly Report* 51(4):900-901, 2002.

The Percentage of Students, Both in Washington and Nationally, Who Have Tried Alcohol is Declining.*

In 1999, underage drinkers (ages 12-20) consumed 19.7% of alcohol consumed in the United States, accounting for \$22.5 billion in total alcohol sales. Roughly half of youth in this age group drink, a proportion similar to that of adults age 21 and older.¹ **Healthy People 2010** sets a target objective of increasing the percentage of high school seniors who have never tried alcohol to 29%.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

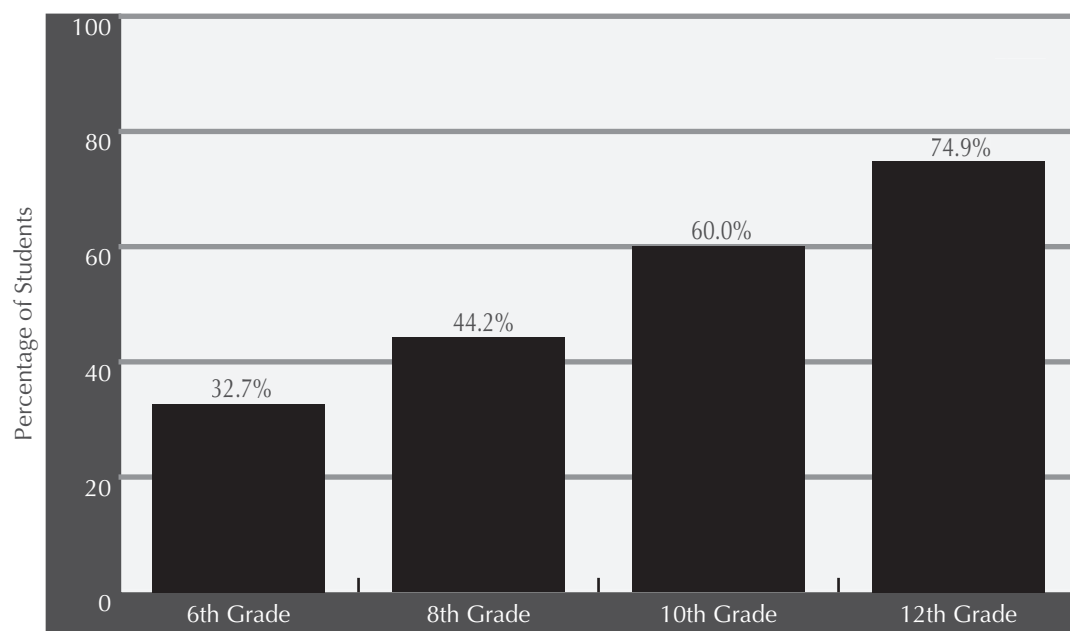


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¹ Foster, S., et al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* Vol. 289 No. 8, February 26, 2003.



Almost a Third of Washington 6th Graders Have Tried Alcohol.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

Teenage drinking can physically damage the brain; interfere with mental and social development; interrupt academic progress; increase chances of risky sexual behavior and teen pregnancy, juvenile delinquency, and crime; compromise health; and result in unintentional injury and death.¹

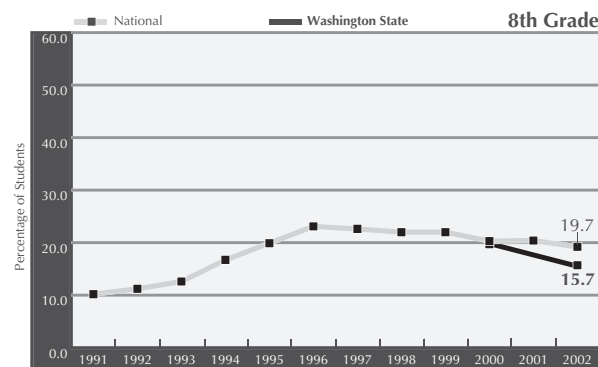
Almost half of Washington students have tried alcohol before they reach high school.

¹ Foster, S., et al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* Vol. 289 No. 8, February 26, 2003.

The Percentage of Students in Washington State Who Have Tried Marijuana is Declining.*

Besides being associated with a variety of health risks, marijuana use can contribute to risky behaviors and adverse physical and social consequences. Marijuana use among students in Washington State appears to be on the decline.

A national study indicates that 36% of youth ages 14-17 report they can purchase illegal drugs within five blocks of their home.¹ **Healthy People 2010** sets a target objective of increasing the percentage of high school seniors who have never used illicit drugs to 56%.



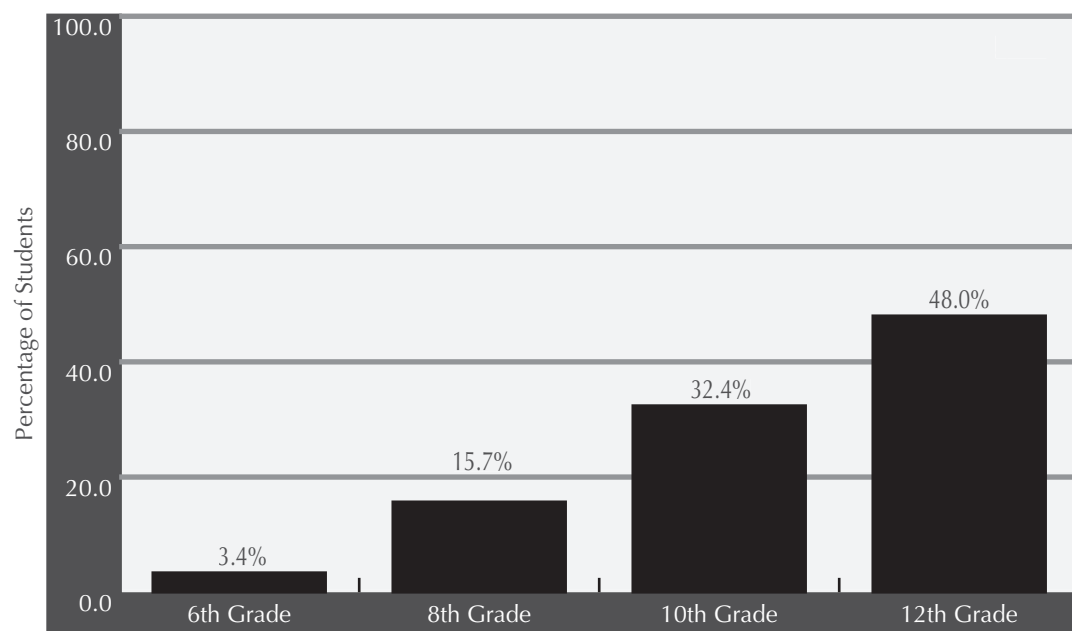
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

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¹ Institute for Adolescent Risk Communication, *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.



By 12th Grade, About Half of Washington Students Have Tried Marijuana.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

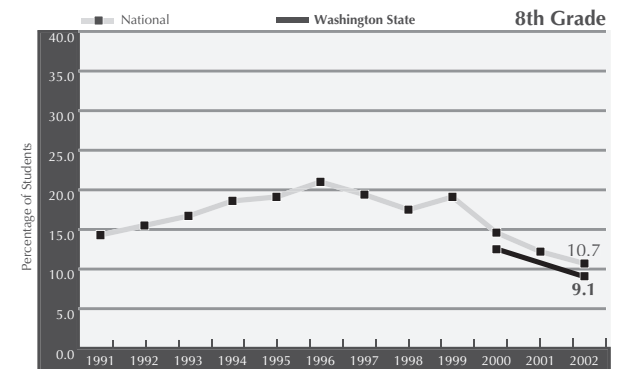
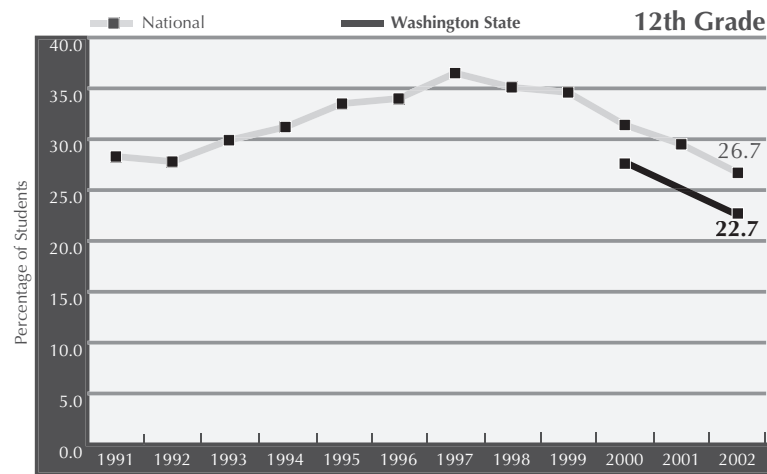
About one-fifth of Washington students begin use of marijuana while they are in middle school. A study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that substance abuse and addiction nationally added \$41 billion, or 10%, to the cost of elementary and secondary education in 2001 due to class disruption and violence, special education and tutoring, teacher turnover, children being left behind, student assistance programs, property damage, injury, and counseling.

CASA also estimates that 60% of high school students and 30% of middle school students attend schools where illegal drugs are kept, sold, and used. Among 10th graders surveyed, 87% said it was easy to get tobacco, 88% to obtain alcohol, and 78% to get marijuana.¹

¹ *Malignant Neglect: Substance Abuse and America's Schools*. New York, NY: The National Center on Addiction and Substance Abuse at Columbia University, 2001.

In 2002, Washington State 8th, 10th, and 12th Graders were Less Likely to Have Smoked a Cigarette in the Past 30 Days than Their National Counterparts.*

Recent smoking by adolescents appears to be on the decline, both in Washington State and nationwide. Studies indicate that youth and young adults smokers are more price-responsive than other smokers, and that a 10% increase in price could reduce the number of teenagers who smoke by 7%.¹ *Healthy People 2010* sets a target objective to reduce cigarette smoking by students in grades 9-12 to 16%.



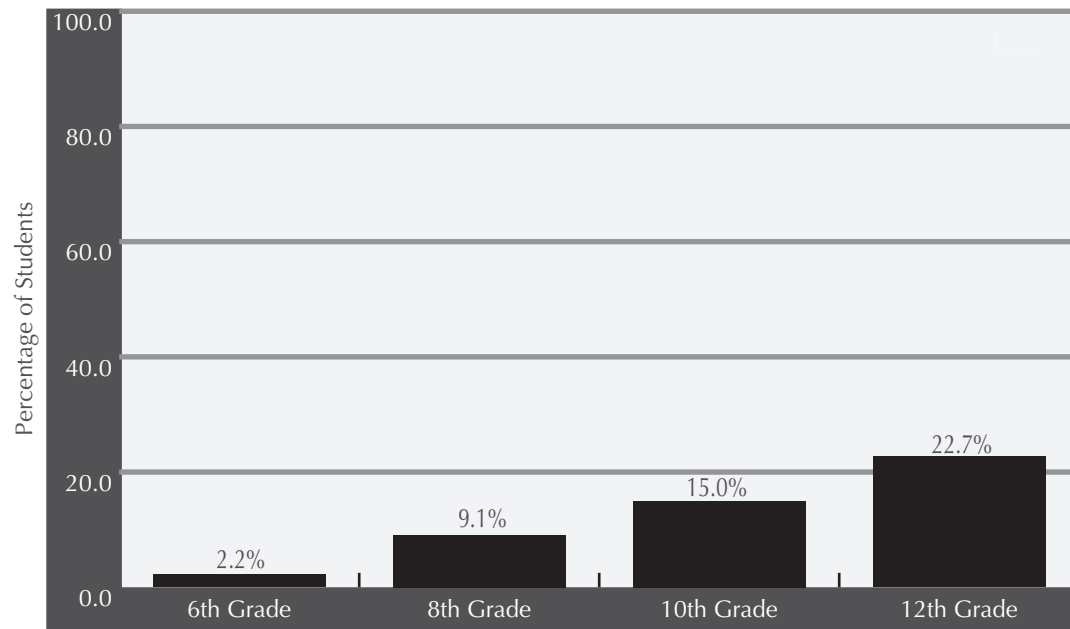
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

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¹ Schneider Institute for Health Policy, Brandeis University, *Substance Abuse—The Nation's Number One Health Problem: Key Indicators for Policy-Update February 2001*. Princeton, NJ: The Robert Wood Johnson Foundation, 2001.



Almost a Quarter of Washington High School Seniors Report Having Smoked a Cigarette in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

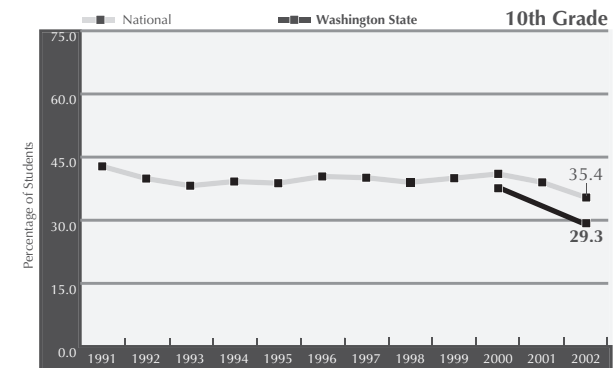
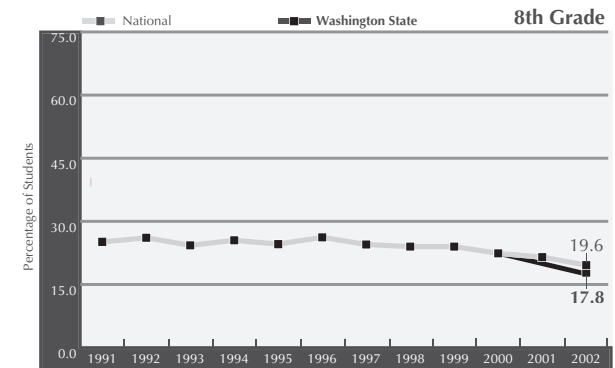
Among young people, short-term health consequences of smoking include respiratory and non-respiratory effects, nicotine addiction, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who begin to smoke regularly in their youth continue to smoke as adults.¹ Nationally, almost 44% of high school seniors who smoke report that they would like to stop smoking. Almost 30% of high school seniors who smoke report that they have tried to quit but have failed to do so.²

¹ U.S. Surgeon General, *Tobacco Use Among Young People – A Report of the Surgeon General*. Washington, DC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.

² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 27-23. Washington, DC: 2000.

Use of Alcohol in the Past 30 Days by Washington State 8th, 10th, and 12th Graders is Declining.*

Recent alcohol use among youth appears to be dropping nationwide. Research indicates that initiation of alcohol use at a young age increases the risk that teenagers will become adult heavier drinkers with alcohol-related problems later in life.¹



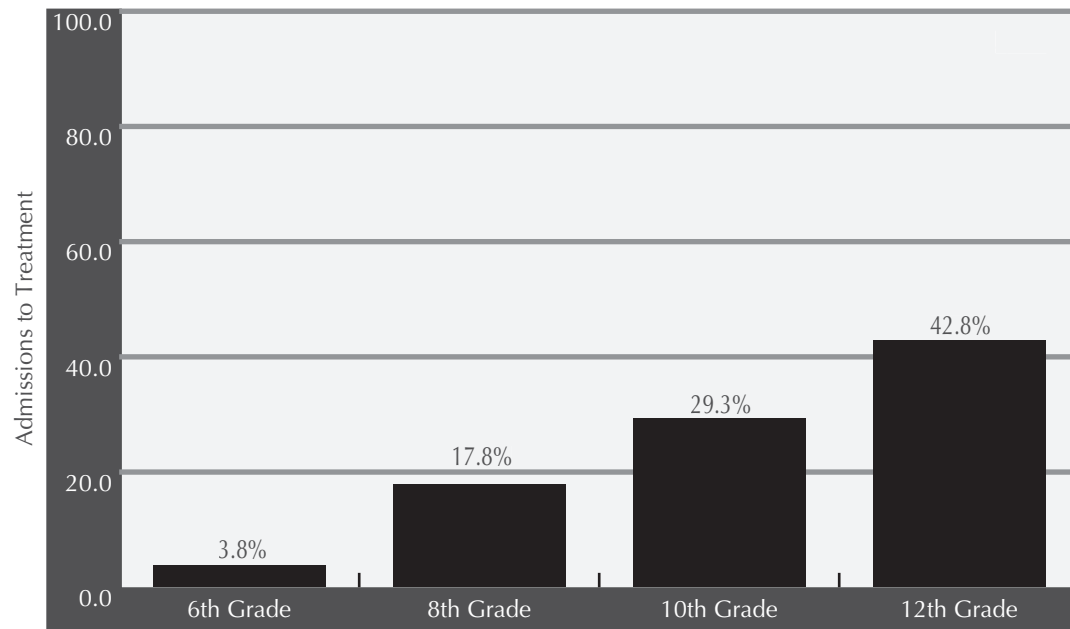
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

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¹ Dewit, D., et al., "Age at First Alcohol Use: A Risk Factor for the Development of Alcohol Disorders," *American Journal of Psychiatry* 157: 745-750, 2000; Grant, B. and Dawson, D., "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey," *Journal of Substance Abuse* 9:103-110, 1997.



Almost One Out of Five Washington 8th Graders Report Having Used Alcohol in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

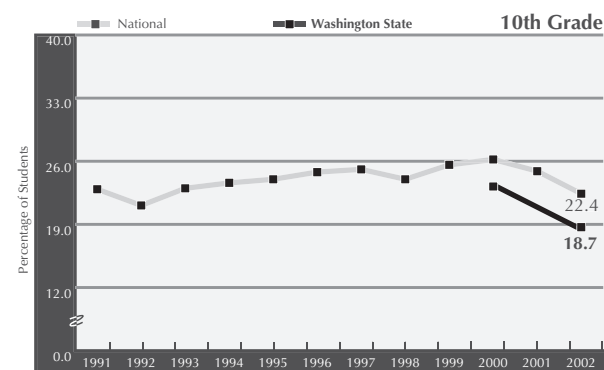
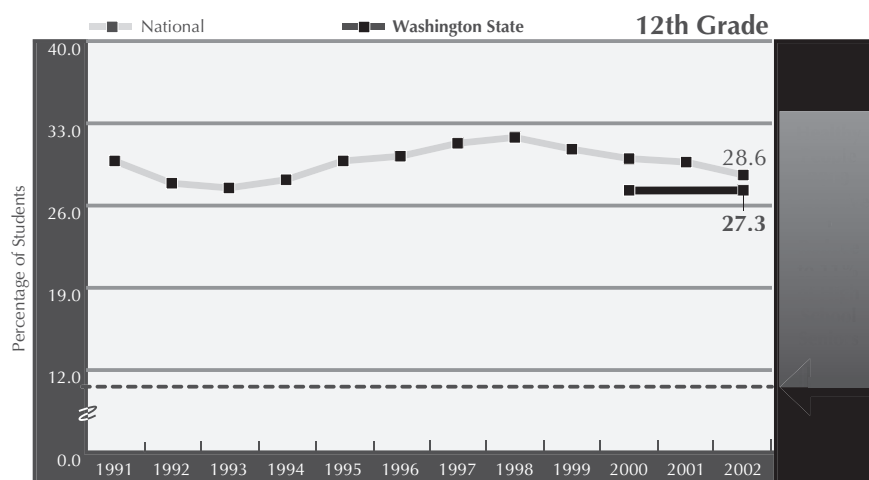
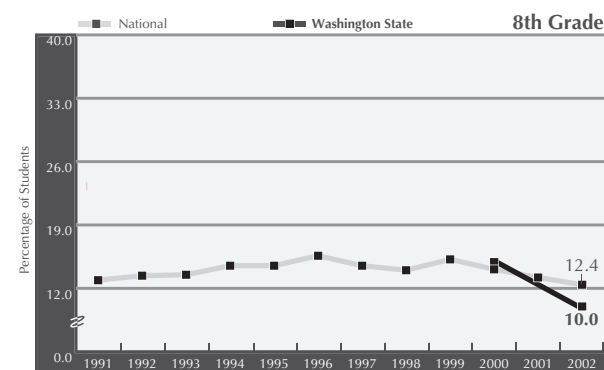
A recent study indicates that youth ages 12-20 are responsible for 19.7% of all alcohol consumed in the United States.¹ Despite the fact that it is illegal, more than 40% of Washington high school seniors report using alcohol in the past 30 days. Teenage drinking is associated with a full range of academic, social, and medical consequences, including juvenile delinquency and crime, risky sexual behavior and teen pregnancy, poor academic progress and school dropout rates, and unintentional injuries and death.²

¹ Foster, S., et al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* 288 (8), February 26, 2003.

² *Ibid.*

Recent Binge Drinking by Washington State 8th, 10th, and 12th Graders is Declining.*

These graphs indicate that in 2002, the percentage of Washington State students engaging in recent binge drinking declined. Recent binge drinking is defined as having five or more drinks in a row on at least one occasion in the past two weeks.



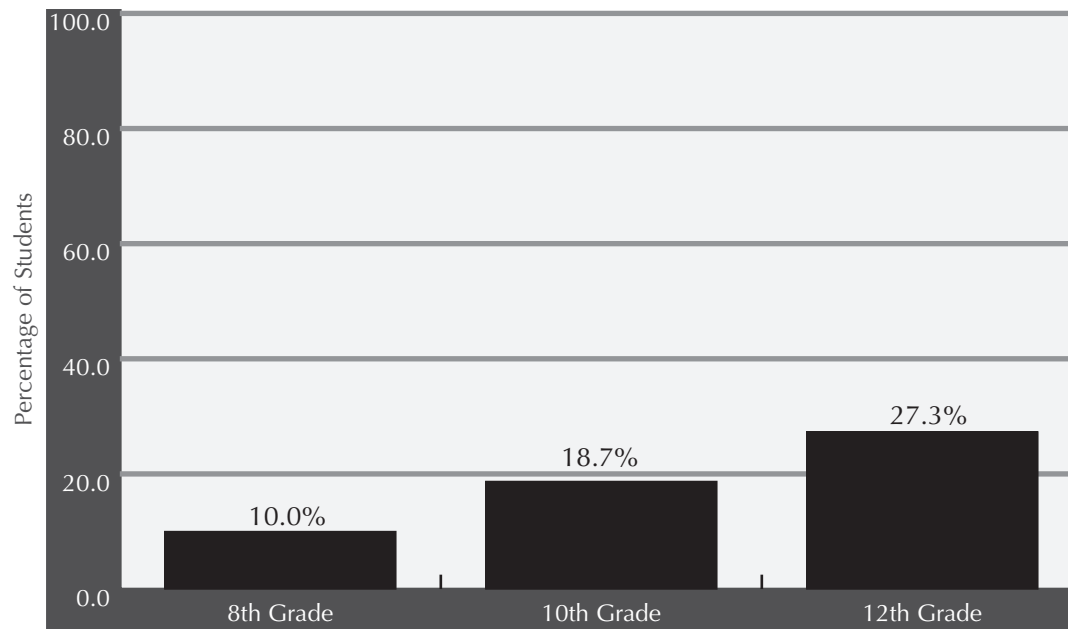
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

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¹ Institute for Adolescent Risk Communication, *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.



More Than a Quarter of Washington Seniors Have Engaged in Recent Binge Drinking.



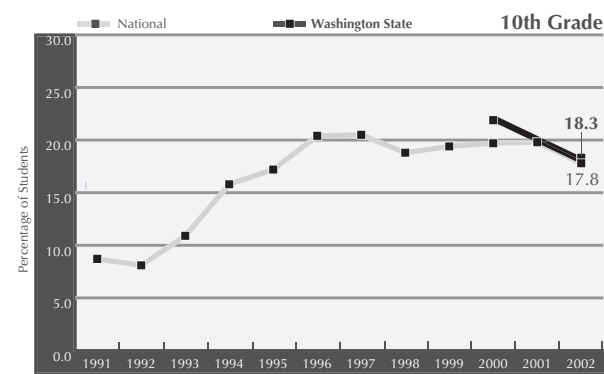
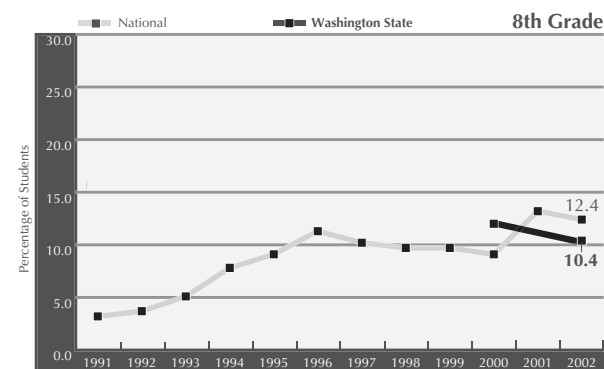
Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2002*.

Recent binge drinking is defined as consuming five or more drinks in a row on at least one occasion in the past two weeks. A 2000 survey of Washington students indicates that binge drinking may start as early as the 6th grade, or earlier.¹ Heavy drinking among youth has been linked to motor vehicle crashes and deaths, physical fights, property destruction, poor school and employment performance, and involvement with law enforcement and the legal system. **Healthy People 2010** sets a target objective to reduce binge drinking among adolescents ages 12-17 in the past month to 3%.

¹ Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2000*. Olympia, WA: 2001.

After Rising Throughout the 1990s, Marijuana Use in the Past 30 Days Among 8th, 10th, and 12th Graders is Beginning to Decline.*

Both nationally and in Washington State, after almost a decade of increases, marijuana use among 8th, 10th, and 12th graders appears to have peaked, and may be beginning to decline.

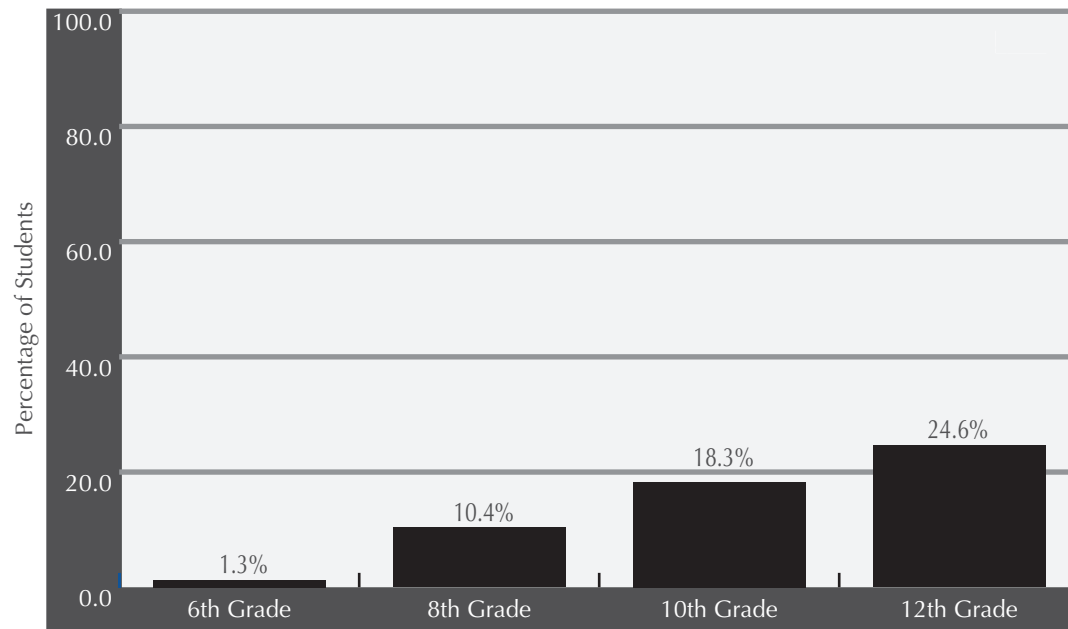


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

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About One Quarter of Washington Seniors Report Having Used Marijuana in the Past 30 Days.

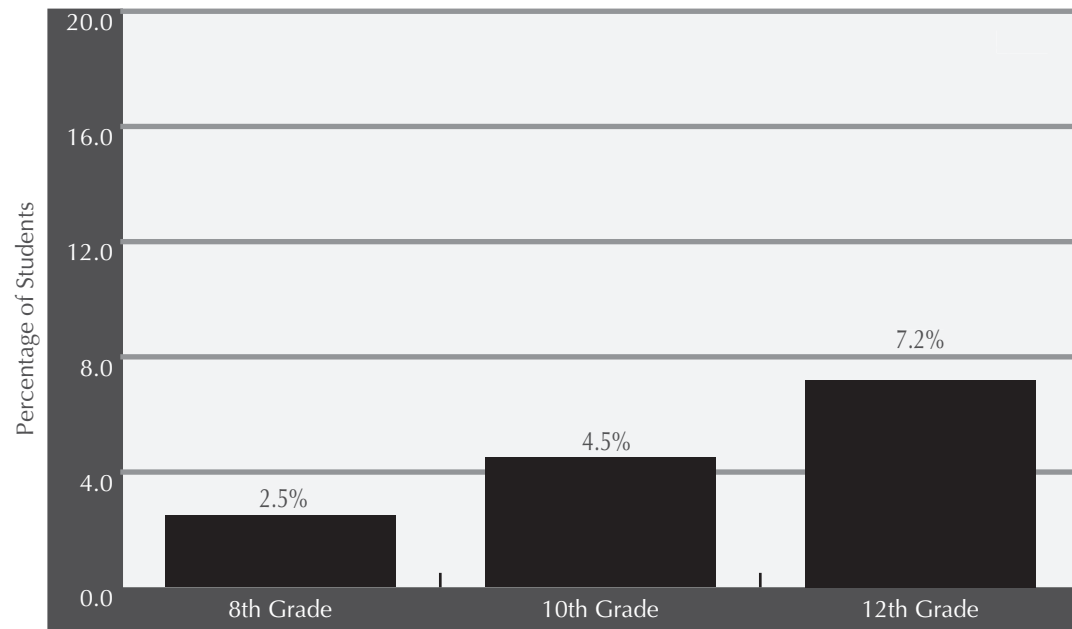


Source: Office of the Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

Marijuana use among adolescents follows a predictable pattern, with the highest incidence of use occurring among high school seniors. **Healthy People 2010** recommends a multicomponent approach to youth substance abuse prevention to increase the effectiveness of efforts. Such an approach would include focusing on mobilizing and leveraging resources, raising public awareness, and countering pro-use messages.¹

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-28. Washington, DC: 2000.

In 2002, More than 7% of Washington State High School Seniors Reported Having Used Methamphetamine.



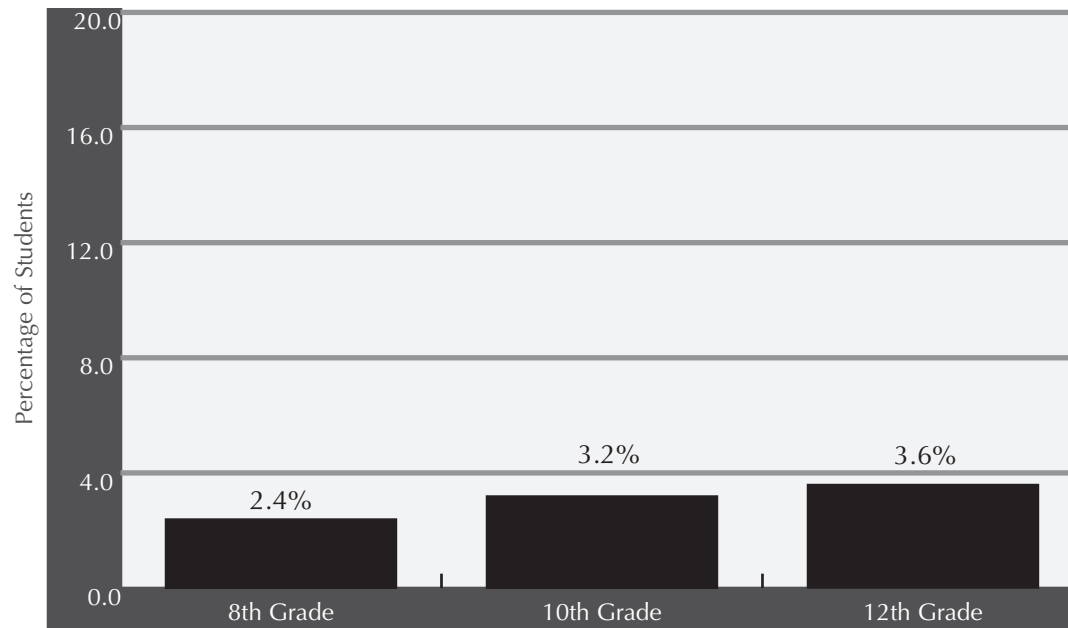
Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2002*.

Researchers funded by the National Institute on Drug Abuse have found a range of negative cognitive effects from use of methamphetamine, often associated with brain cell damage. Some of this damage is long-term, and users may not fully recover after they become abstinent.¹ Recent data from the *Washington State Survey of Adolescent Health Behaviors–2002* suggest that lifetime methamphetamine use among Washington State teenagers may have peaked.

¹ National Institute on Drug Abuse, "Brain Imaging Studies Show Long-Term Damage from Methamphetamine Abuse," *NIDA Notes* 15 (3), August 2000; National Institute on Drug Abuse, "Methamphetamine Abuse Linked to Impaired Cognitive and Motor Skills Despite Recovery of Dopamine Transporters," *NIDA Notes* 17(1), April 2002.



In 2002, 3.6% of Washington State High School Seniors Reported Having Used MDMA/Ecstasy in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2002*.

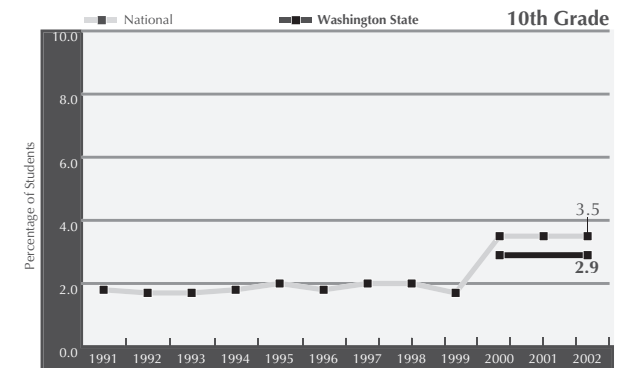
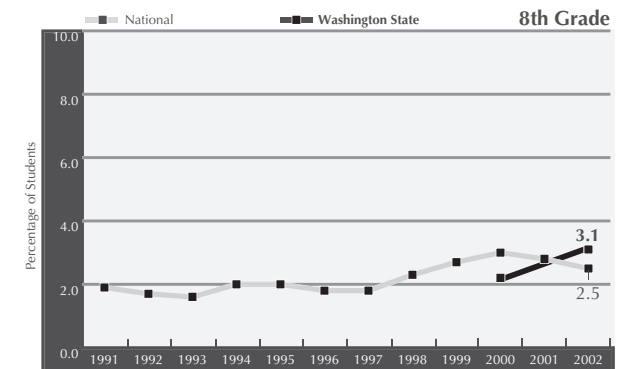
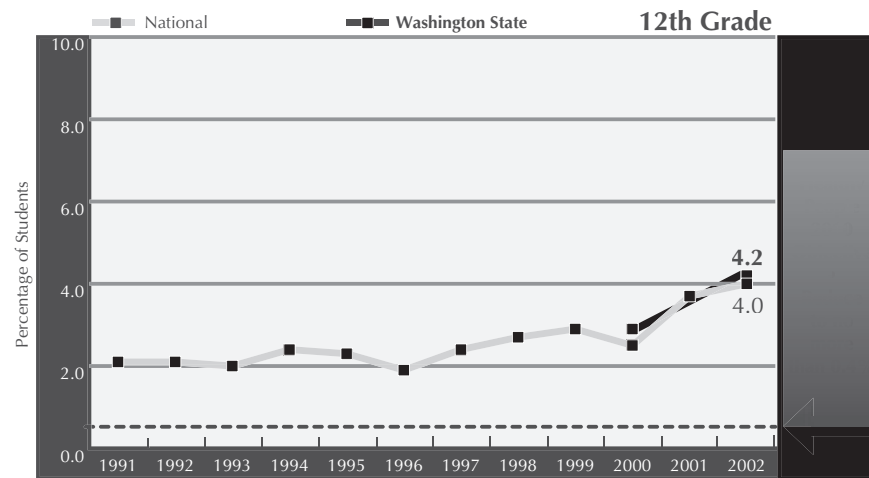
MDMA/Ecstasy, one of a variety of substances often called “club” or “party” drugs because of where they are ingested, has been shown to produce long-lasting damage to the neurons that release serotonin, and may be associated with depression, sleep disorders, anxiety, and memory impairment.¹ Nationally, the *Monitoring the Future* 2002 survey indicates that more than 10% of high school seniors have experimented with MDMA/Ecstasy at least once.²

¹ National Institute on Drug Abuse, *NIDA Community Drug Alert Bulletin – Club Drugs*, December 1999.

² Johnston, L., O'Malley, P., and Bachman, J., *Monitoring the Future National Results on Adolescent Drug Use: Overview of Key Findings, 2002*. Bethesda, MD: National Institute on Drug Abuse, 2003.

In 2002, More than 4% of Washington State Male High School Seniors Reported Having Used Steroids at Least Once.*

Behavioral and health problems associated with steroid use include suicides, homicides, liver damage, and heart attacks.¹ Lifetime use of steroids in Washington State appears to be increasing among high school students, and age of first use is declining. While substantially more males than females use steroids, use among female high school students may be increasing as well.



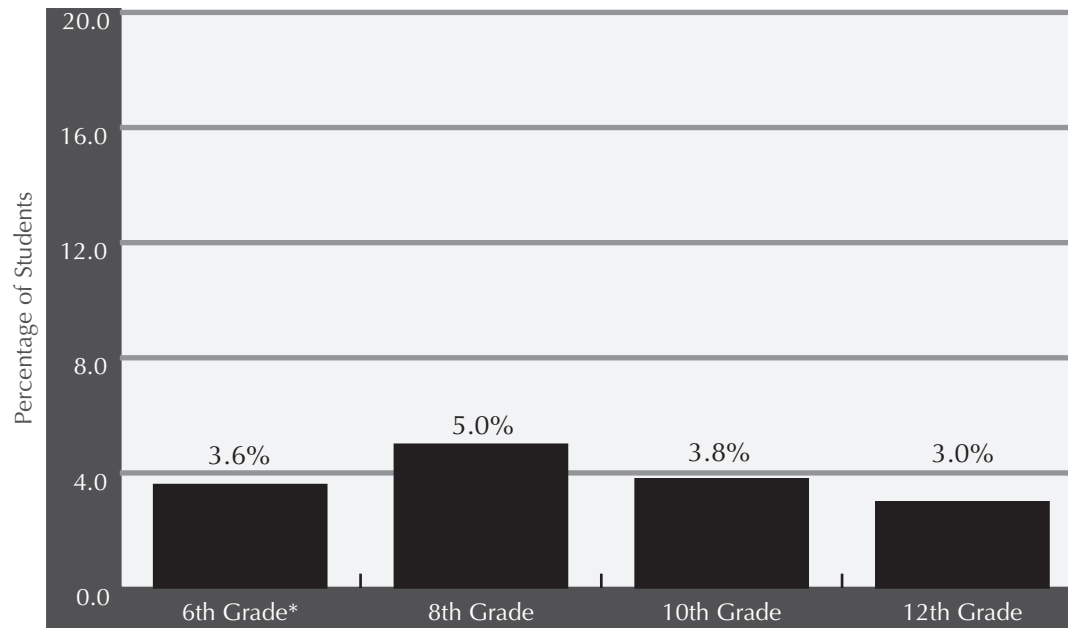
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

*The Washington State Survey of Adolescent Health Behaviors (WSSAHB) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between WSSAHB and MTF thus should not be made, except for the purpose of viewing trends.

¹ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-36. Washington, DC, 2000.



Use of Inhalants in the Past 30 Days Among Washington State Students Peaks in the 8th Grade.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

Inhalants are substances whose vapors can be inhaled to produce a mind-altering effect. They include volatile solvents (paint thinners, degreasers, and glues); aerosols (hair sprays and vegetable oil sprays); ether, nitrous oxide, and propane; and nitrites. A single, prolonged session of inhalant use can produce rapid and irregular heart rhythms, heart failure, and death. Chronic exposure can cause widespread and long-lasting damage to the nervous system and other vital organs.¹

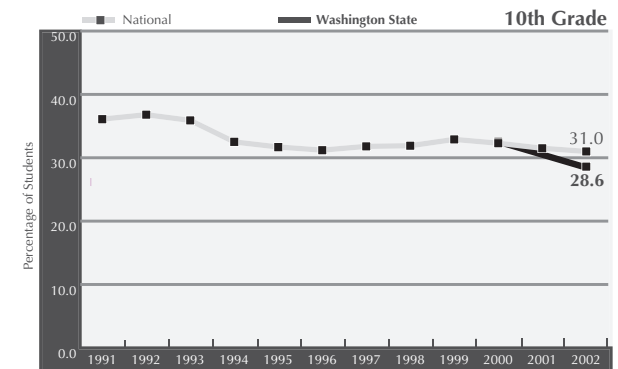
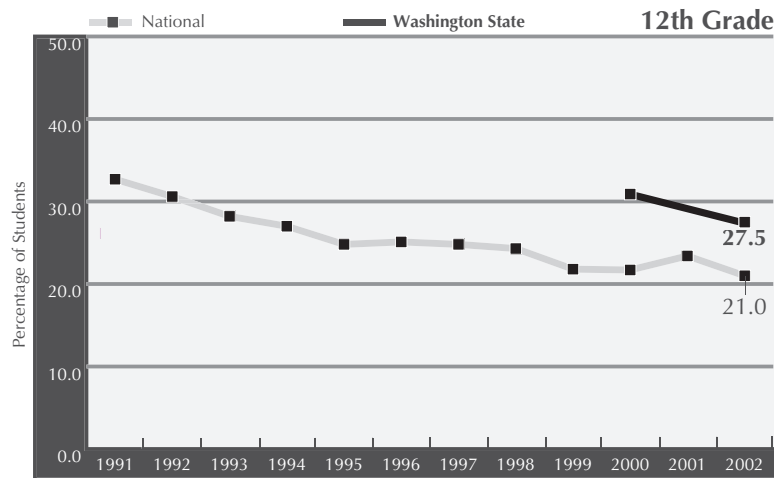
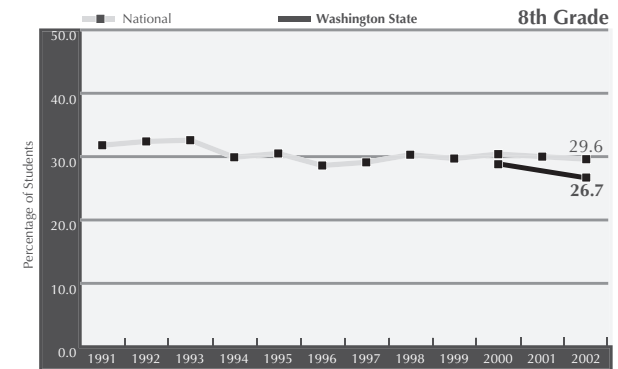
In 2002, Washington State 8th graders reported the highest use of inhalants in the previous 30 days. Thereafter, unlike the pattern for other drug and alcohol use, inhalant use declines.

*6th grade percentage is for lifetime use; other grades are for past 30-day use.

¹ National Institute on Drug Abuse, "Facts About Inhalant Abuse," *NIDA Notes* 15 (6), January 2001.

Only About a Quarter of Washington State 8th, 10th, and 12th Graders Perceive Great Risk from Drinking 1-2 Alcoholic Drinks Nearly Every Day.*

This graph indicates that almost three-quarters of Washington State 8th, 10th, and 12th grade students do not perceive great risk in near-daily alcohol consumption. National data indicate that student perception of risk regarding both regular use of alcohol use and heavy drinking is declining, perhaps suggesting that alcohol use is becoming more acceptable among students.

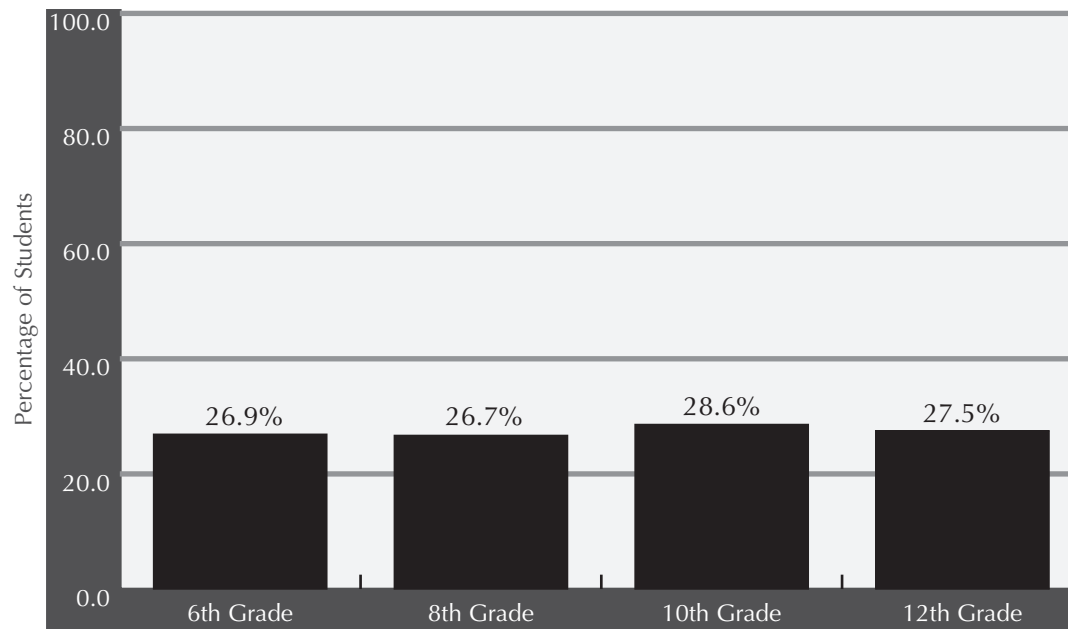


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

*The Washington State Survey of Adolescent Health Behaviors (WSSAHB) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between WSSAHB and MTF thus should not be made, except for the purpose of viewing trends.



The Percentage of Washington State Students in 6th, 8th, 10th, and 12th Grade Who Perceive Great Risk from Drinking 1-2 Alcohol Drinks Nearly Every Day Appears to Be Declining.



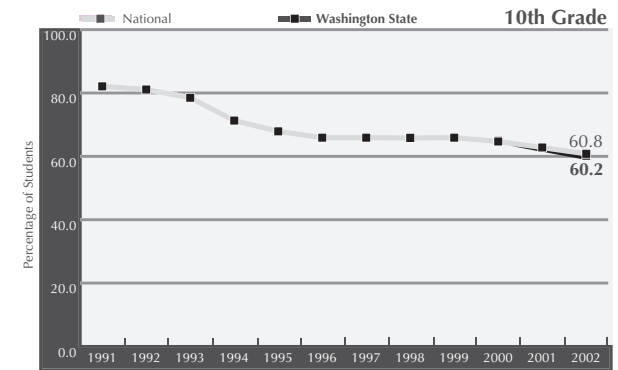
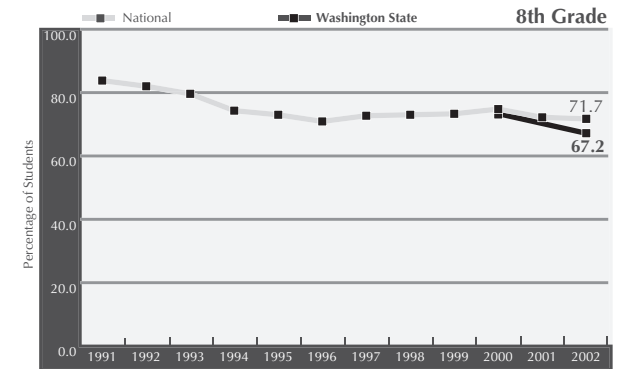
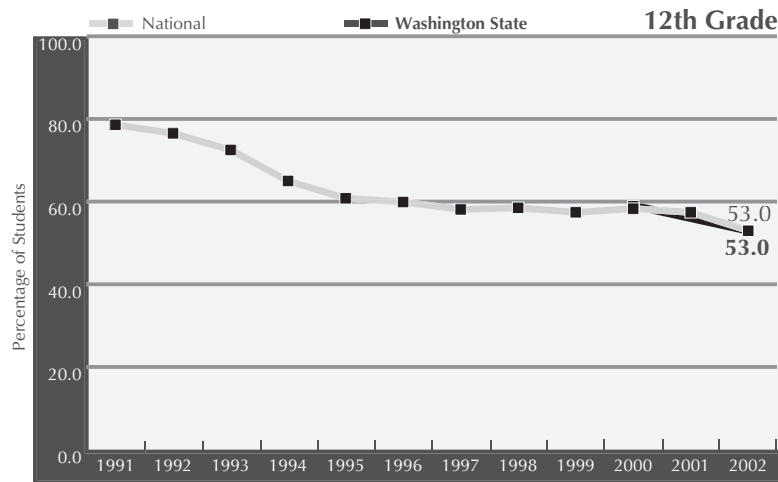
Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

Research indicates that attitudes about specific drugs and alcohol are among the most important determinants of actual use.¹ Perception of great risk from near-daily use of alcohol among Washington State students actually declined at all grades levels from the *Washington State Survey of Adolescent Risk Behaviors–2000*. This may be due to the fact that, despite repeated prevention messages delivered in the school environment, students are barraged with advertising messages actively promoting alcohol use.

¹ Bachman, J., Johnston, L., and O'Malley, P., "Explaining Recent Increase in Students' Marijuana Use: Impacts of Perceived Risks and Disapproval," *American Journal of Public Health* 88 (6), 1988.

Nationally, the Percentage of 8th, 10th, and 12th Graders Who Perceive Great Risk from Regular Marijuana Use is in Serious Decline.*

Perception of risk from regular marijuana use has been declining, in some instances, steeply, among 8th, 10th, and 12th grade students. Nationally, among 12th grade students, the percentage of 12th grade students who perceive great risk from regular marijuana use is at its lowest point since 1980.

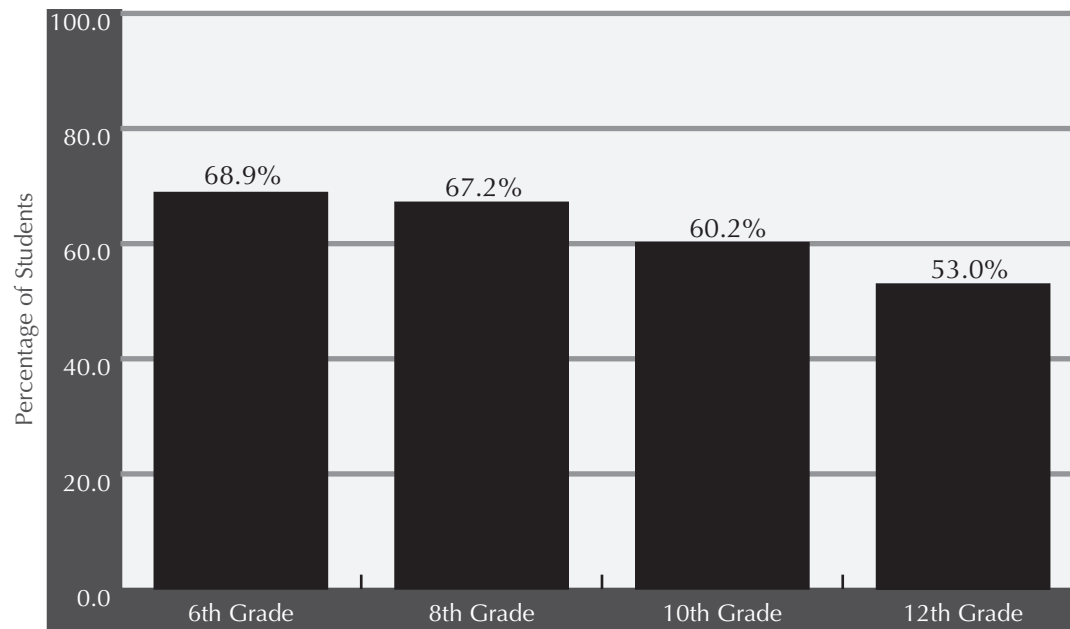


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors*.

*The Washington State Survey of Adolescent Health Behaviors (WSSAHB) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between WSSAHB and MTF thus should not be made, except for the purpose of viewing trends.



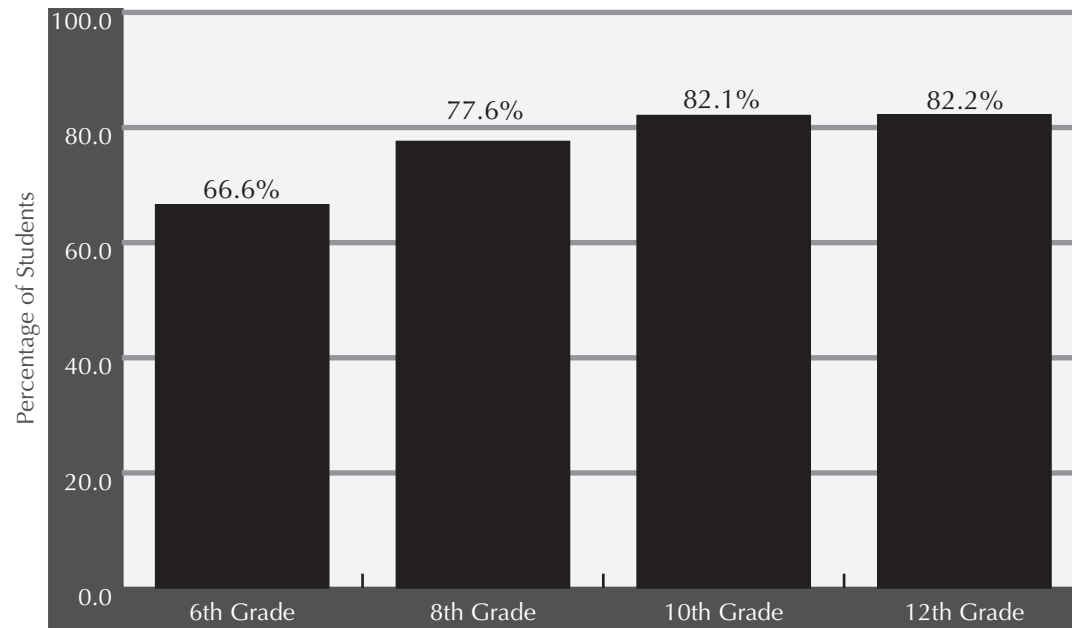
The Percentage of Washington State Students Who Perceive Great Risk from Marijuana Use Declines as They Get Older.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors* – 2002.

The percentage of students, both in Washington State and nationally, who perceive great risk from regular marijuana use declines as they get older. This is contrary to the way students perceive the risk of regular cigarette use, which increases as students get older. In 2002, at all grade levels, a lower percentage of Washington State students perceived great risk from regular marijuana use than in 2002.

In 2002, Most Washington State Students Perceive Great Risk from Smoking One or More Packs of Cigarettes Per Day.



Source: Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors – 2002*.

While most Washington State students perceive great risk from smoking one or more packs of cigarettes every day, the percentage of students who perceive such risk has dropped in every grade since the *Washington State Survey of Adolescent Health Behaviors – 2000*. In the case of 6th graders, the drop was substantial, from 77.2% to 66.6%.



Peer Substance Abuse Has Significant Negative Impacts on School Performance.

In a study undertaken by Washington Kids Count at the University of Washington's Human Services Policy Center, data from the results of the 1999 Washington Assessment on Student Learning tests were linked with the results of the 1998 Washington Survey of Adolescent Health Behaviors administered in Washington schools. Peer substance use was calculated as the average level of alcohol or drug use by students of the same age, gender, and race-ethnic group in the school.

Among middle schoolers:

- *Students whose peers had little or no involvement with drinking and drugs scored substantially higher than students whose peers had a low level of drinking or drug use.*
- *The entire average difference in whether or not students met the state reading and math standards was accounted for by the degree to which their peers used alcohol or other drugs.*
- *The most important factors reliably indicating the level of substance abuse in a school are whether students start antisocial behavior at an early age, whether the prevailing attitudes of the students condone or condemn antisocial behavior, and whether students have opportunities for productive involvement in school and community activities.¹*

¹Brandon, R., *Impact of Peer Substance Use on Middle School Performance in Washington: Summary*. Seattle, WA: University of Washington, Human Services Policy Center, Washington Kids Count, 2001.

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE



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graph LR; P[PREVALENCE] --- A[Adolescent Substance Use and Beliefs]; P --- B[Adult Substance Use]
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Adolescent
Substance
Use and Beliefs

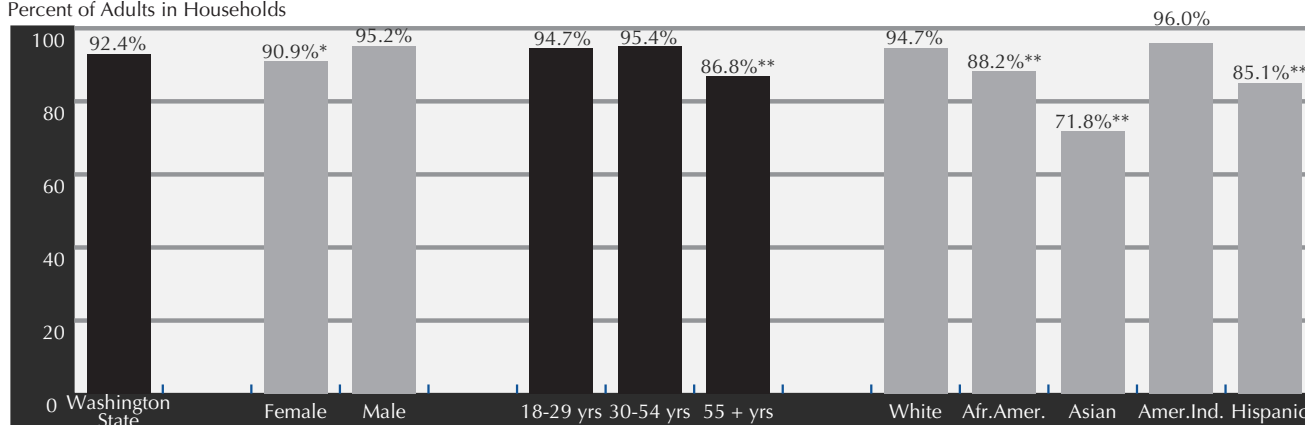
Adult
Substance
Use



Being Age 55 or Older, Female, or of Minority Racial/Ethnic Status Are Associated with LOWER Lifetime and Past 30-Day Alcohol Use Rates.

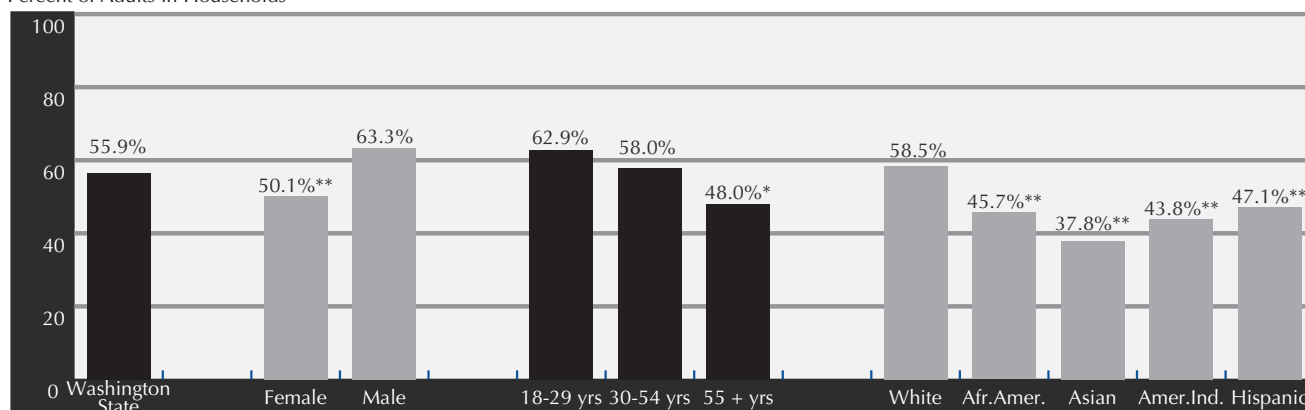
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30 Day Use of Alcohol

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

Note: Past 30 day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

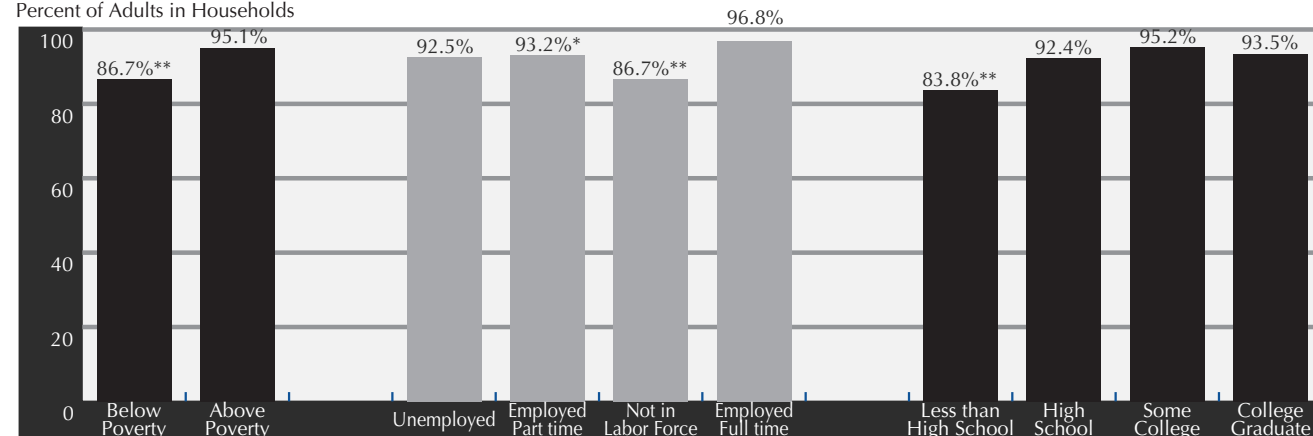
Note: Starred groups are "statistically" significantly different from their reference group. $p < .10^*$, $p < .05^{**}$.

Being Poor, Not in the Labor Force*, or Having No High School Diploma Are Associated with LOWER Lifetime and 30-Day Alcohol Use Rates.



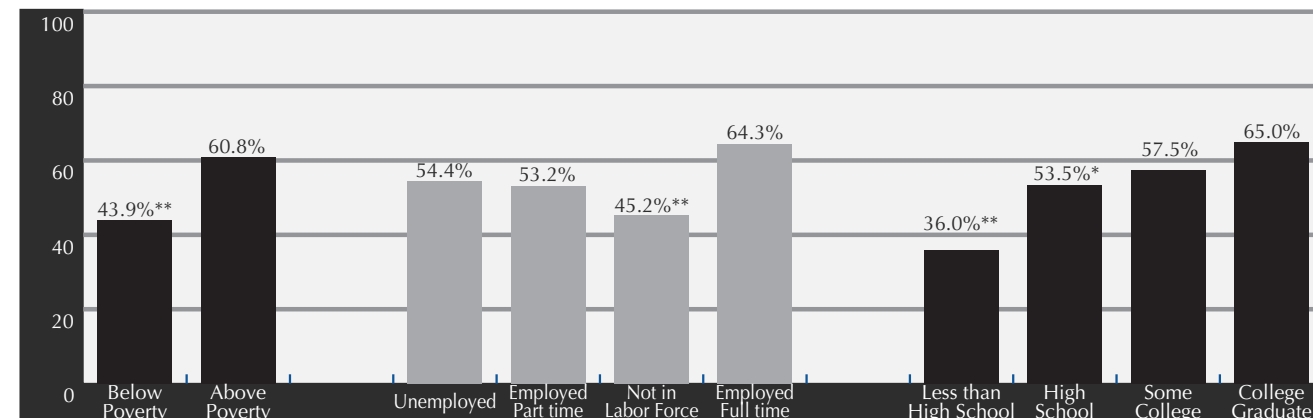
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30 Day Use of Alcohol

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

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Note: Starred groups are "statistically" significantly different from their reference group. $p < .10^*$, $p < .05^{**}$.

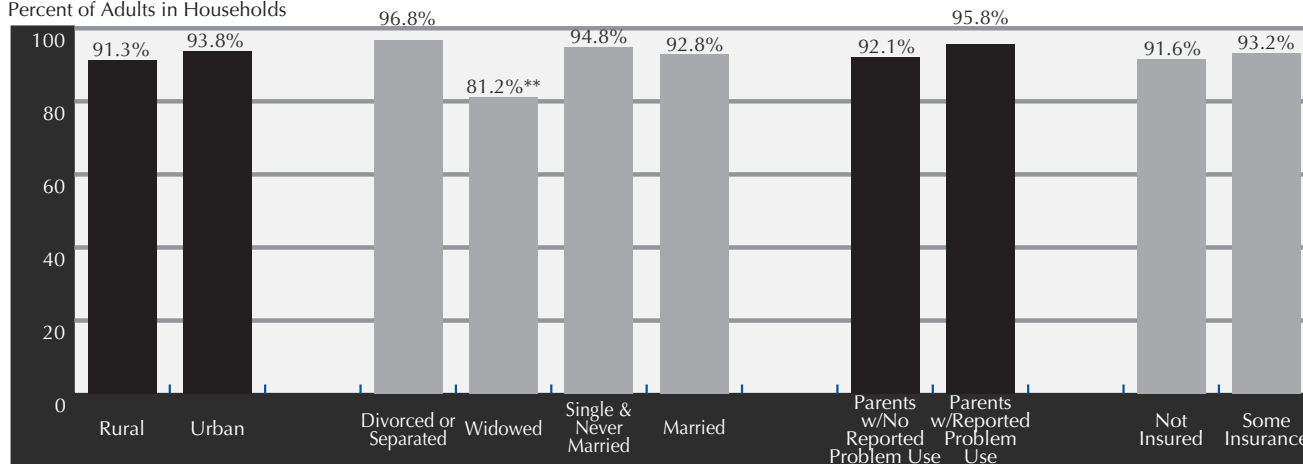
*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Full-Time Student.



Being Widowed is Associated with LOWER Lifetime and 30-Day Alcohol Use Rates.

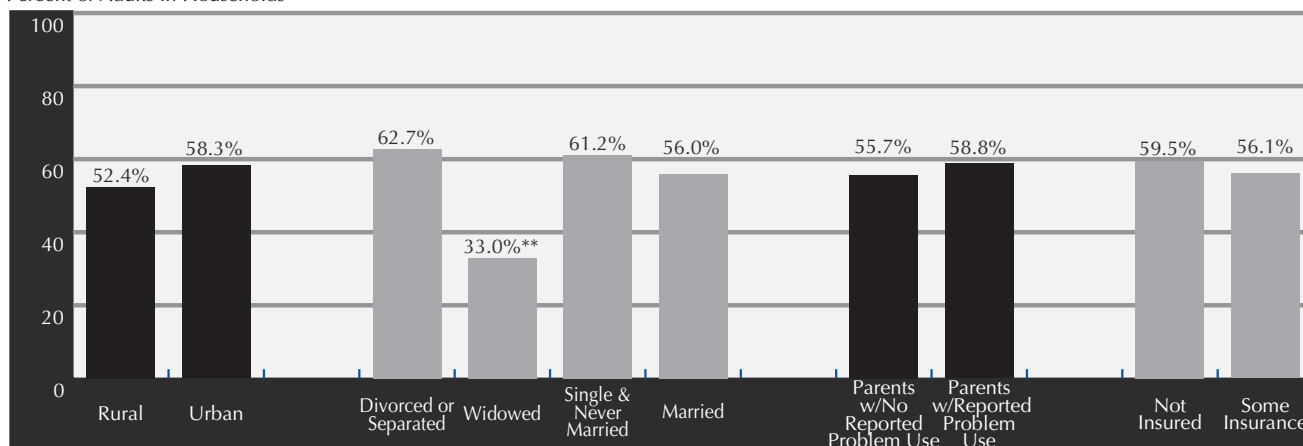
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30 Day Use of Alcohol

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

Note: Past 30 day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

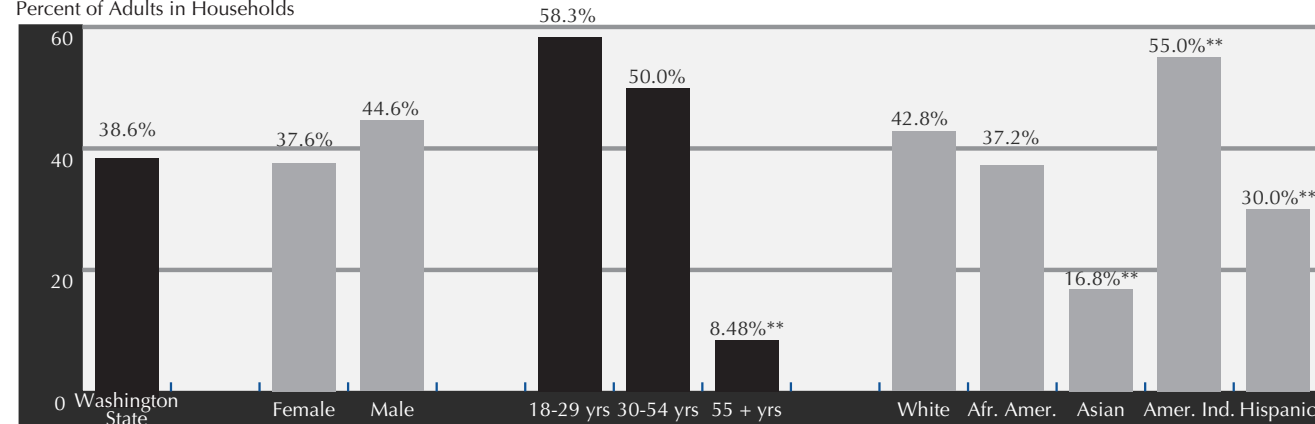
Note: Starred groups are "statistically" significantly different from their reference group. $p < .10^*$, $p < .05^{**}$.

Being Age 55 or Older, Asian, Hispanic or Female are Associated with LOWER Lifetime and Past 30-Day Marijuana Use Rates.



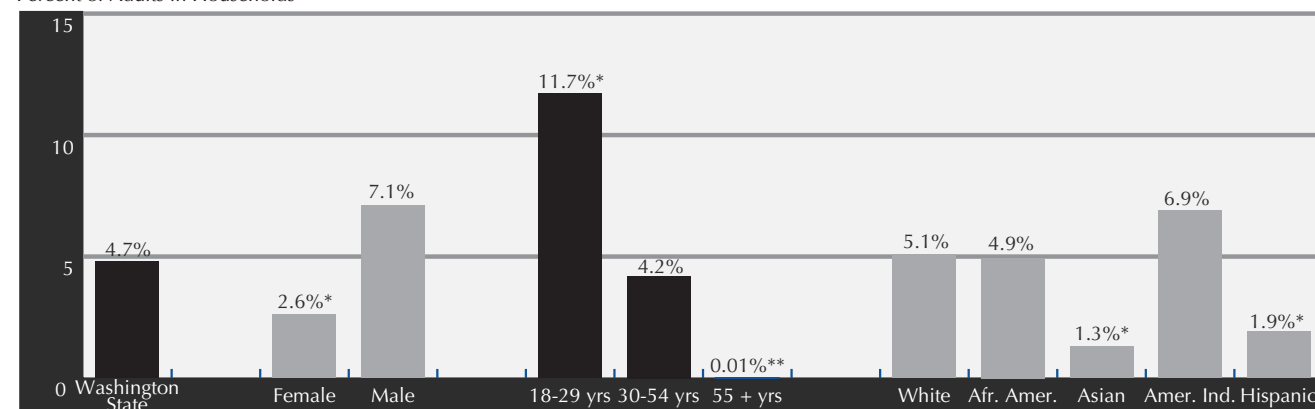
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30 Day Use of Marijuana

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

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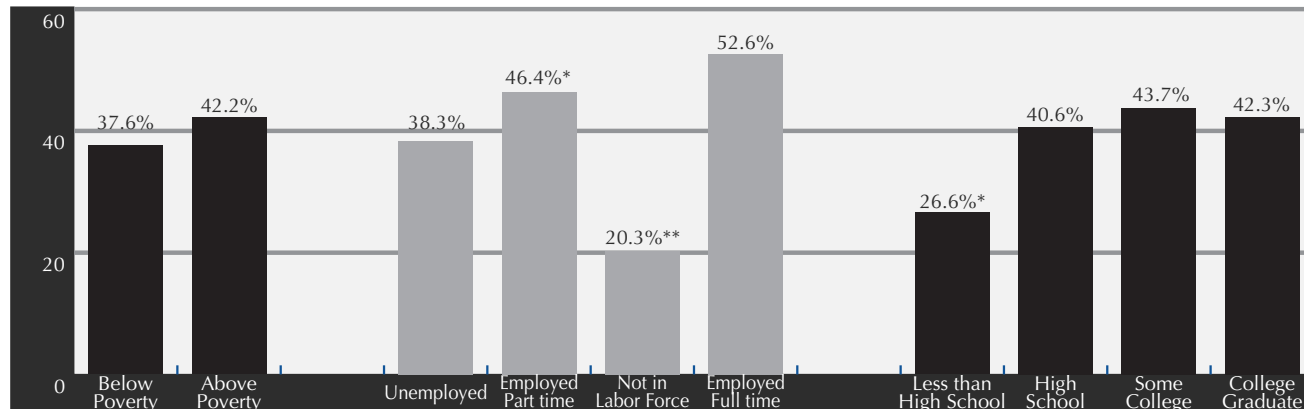
Note: Starred groups are "statistically" significantly different from their reference group. $p < .10^*$, $p < .05^{**}$.



Not Being in the Labor Force* is Associated with LOWER Lifetime and Past 30-Day Marijuana Use Rates.

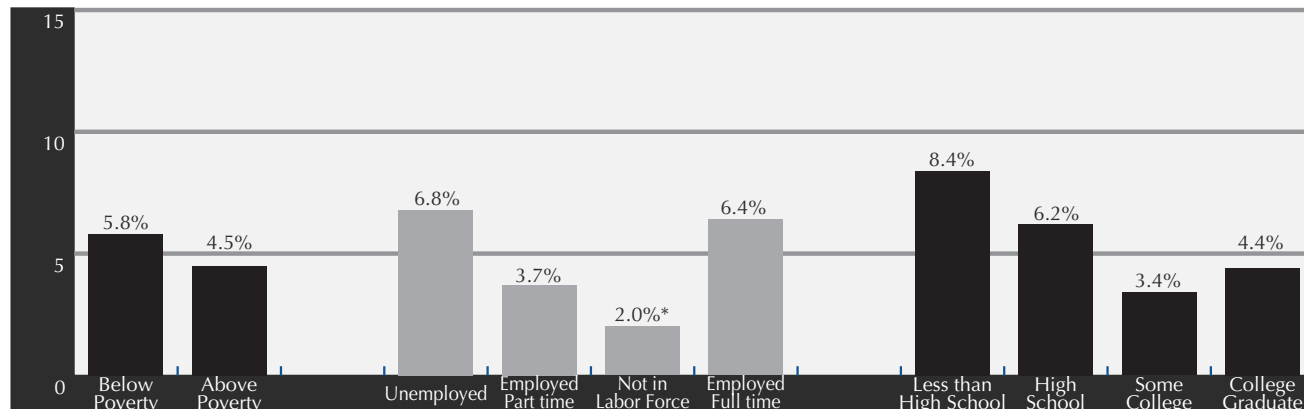
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30 Day Use of Marijuana

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

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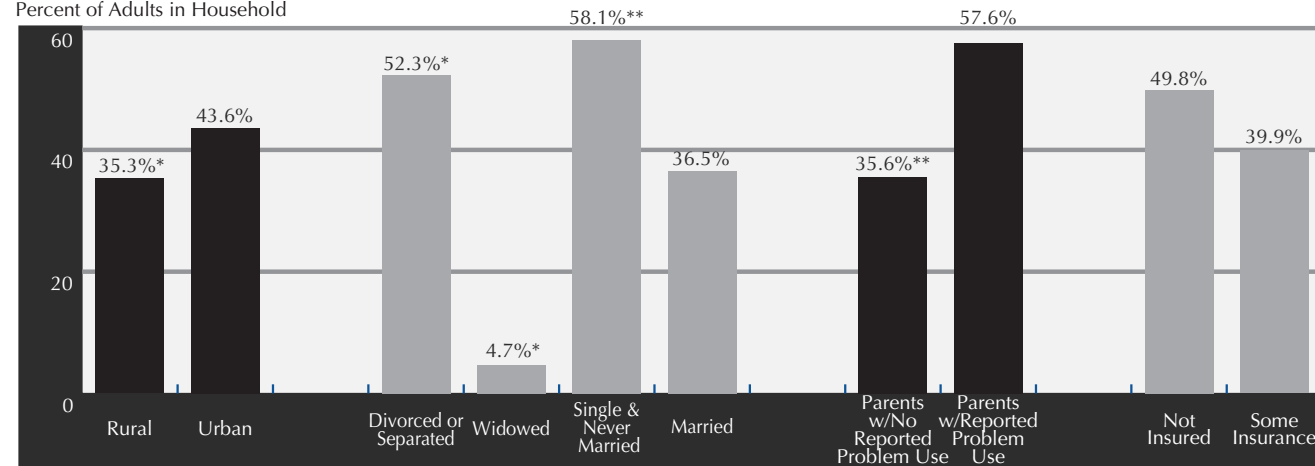
*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Full-Time Student.

Being Single and Never Married, Divorced or Separated, or Having Parents with Reported Drug or Alcohol Problems are Associated with HIGHER Lifetime and Past 30-Day Marijuana Use Rates.



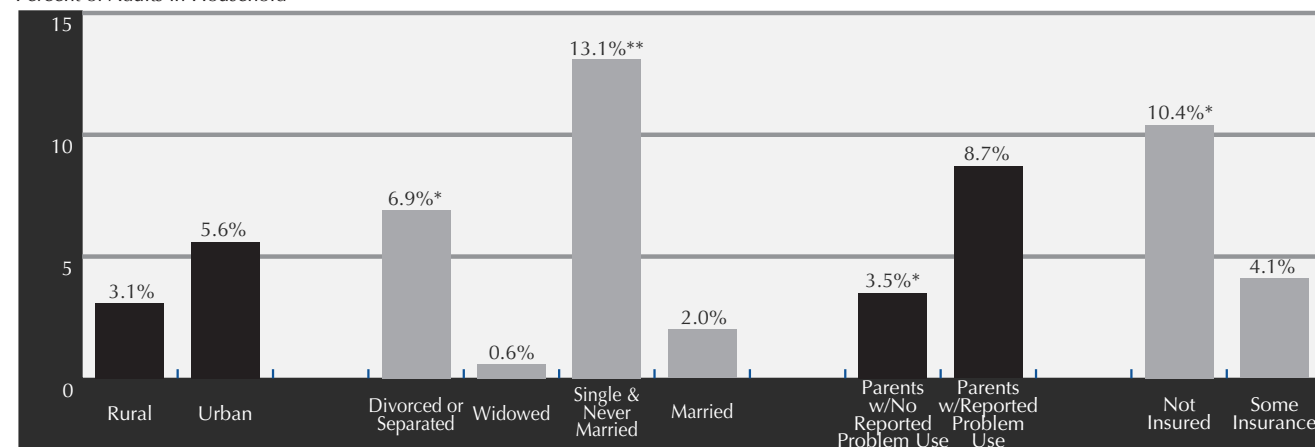
Lifetime Use of Marijuana

Percent of Adults in Household



Past 30 Day Use of Marijuana

Percent of Adults in Household



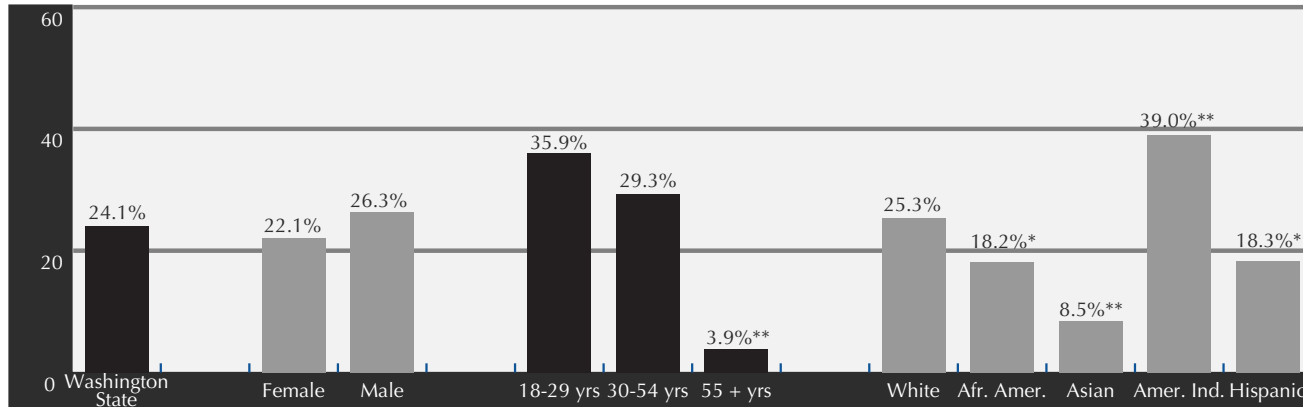
Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
 Note: Past 30 day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.
 Note: Starred groups are "statistically" significantly different from their reference group. $p < .10^*$, $p < .05^{**}$.

Persons Who Were Age 55 or Older, or Asian Reported LOWER Rates of Both Lifetime and Past Year Hard Drug Use. HIGHER Lifetime Hard Drug Use was Reported by American Indians. HIGHER Past Year Hard Drug Use was Reported by Young Adults Under 30.

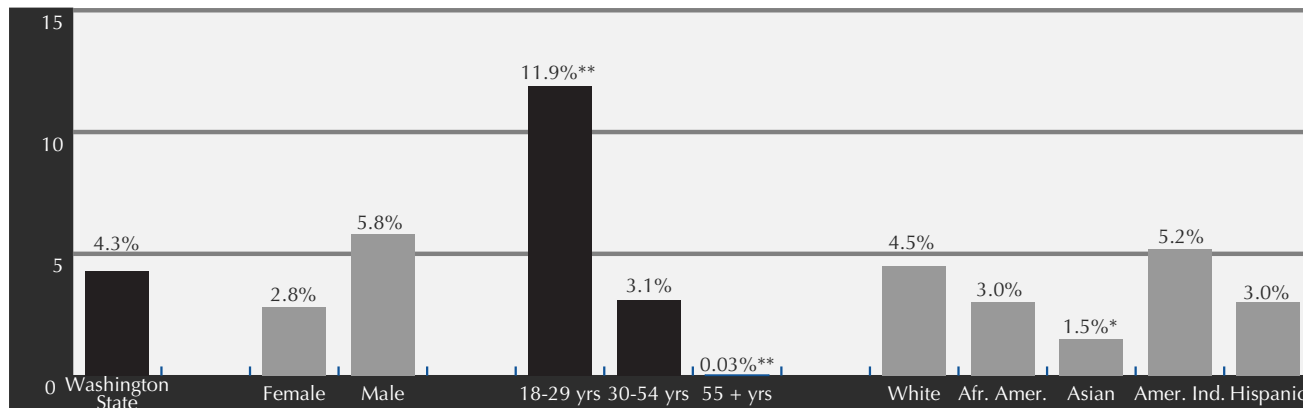
Lifetime Use of Hard Drugs

Percent of Adults in Households



Past 12 Month Use of Hard Drugs

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

Note: Past 30 day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Note: Starred groups are "statistically" significantly different from their reference group. p<.10*, p<.05**.

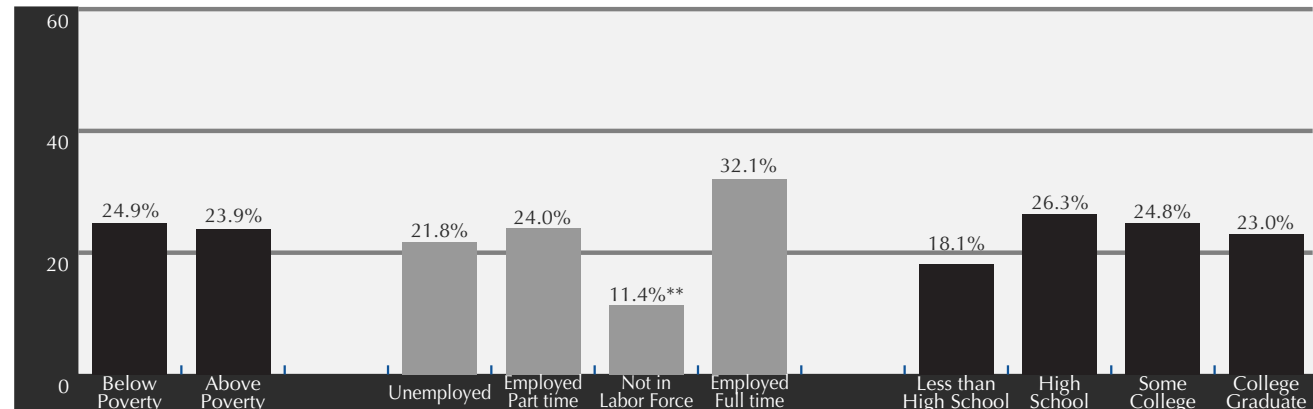
*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Full-Time Student.

People Who Were Not in the Labor Force* Reported Lower Rates of Lifetime and Past Year Use of Hard Drugs.



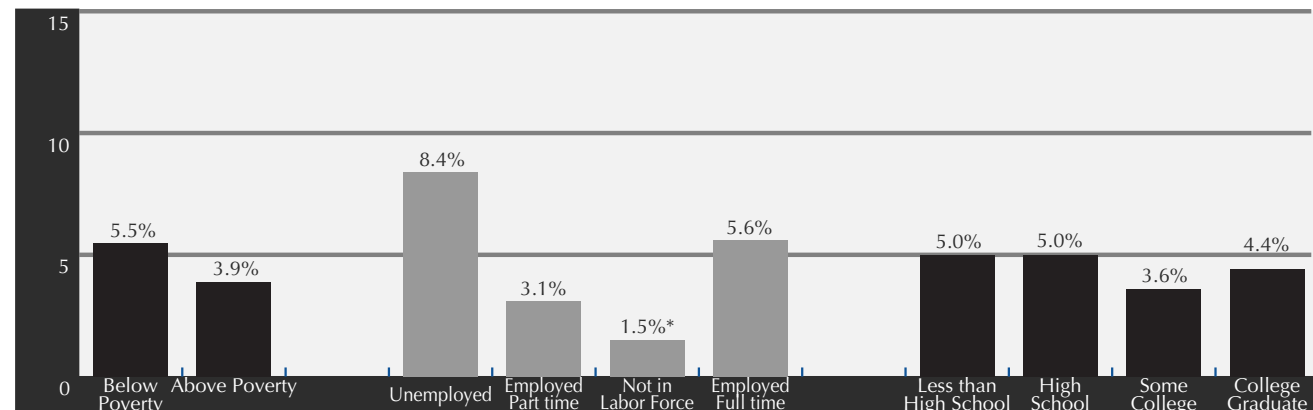
Lifetime Use of Hard Drugs

Percent of Adults in Households



Past 12 Month Use of Hard Drugs

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

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Note: Starred groups are "statistically" significantly different from their reference group. $p < .10^*$, $p < .05^{**}$.

*Not in Labor Force means Not Employed AND either Retired, OR a Full-Time Homemaker, OR a Fulltime Student.

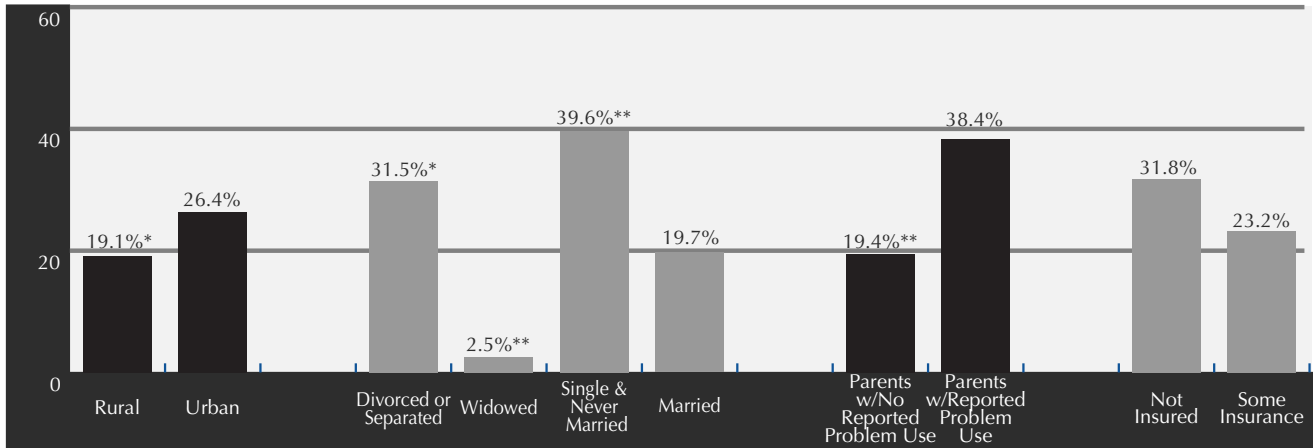
**"Hard drugs" are any of the following substances used for non-medical purposes: sedatives, heroin, stimulants, hallucinogens, and other opiates.

People Who Were Divorced or Separated, Single and Never Married, Lived in Urban Counties, or Had Parents with Problem Drug or Alcohol Use Reported HIGHER Lifetime Use of Hard Drugs. All but the Last Condition were Also associated with HIGHER Past Year Hard Drug Use Rates.



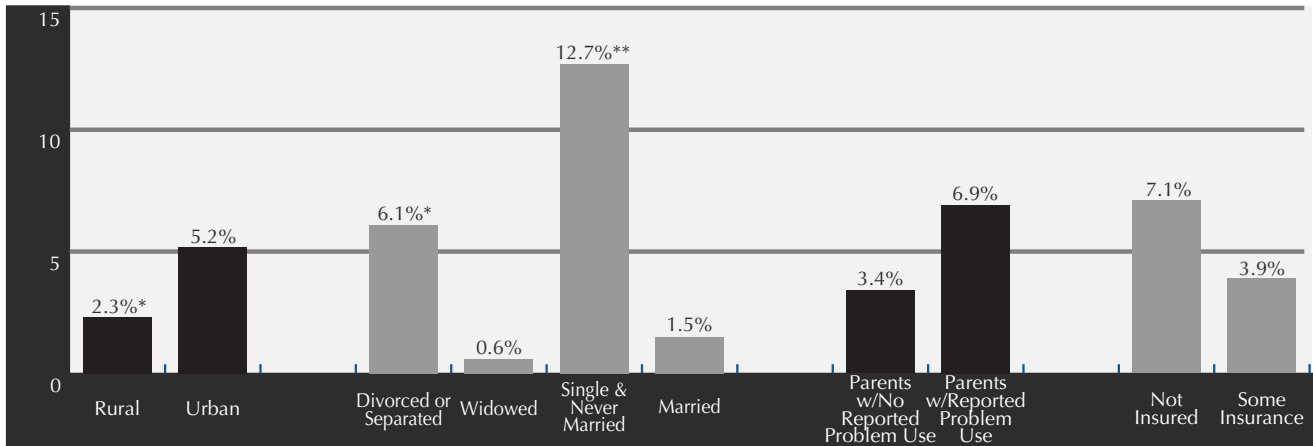
Lifetime Use of Hard Drugs

Percent of Adults in Household



Past 12 Month Use of Hard Drugs

Percent of Adults in Household



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, Washington State Needs Assessment Household Survey (WANAHS) and Profile of Substance Use and Need for Treatment Services in Washington State (1999).

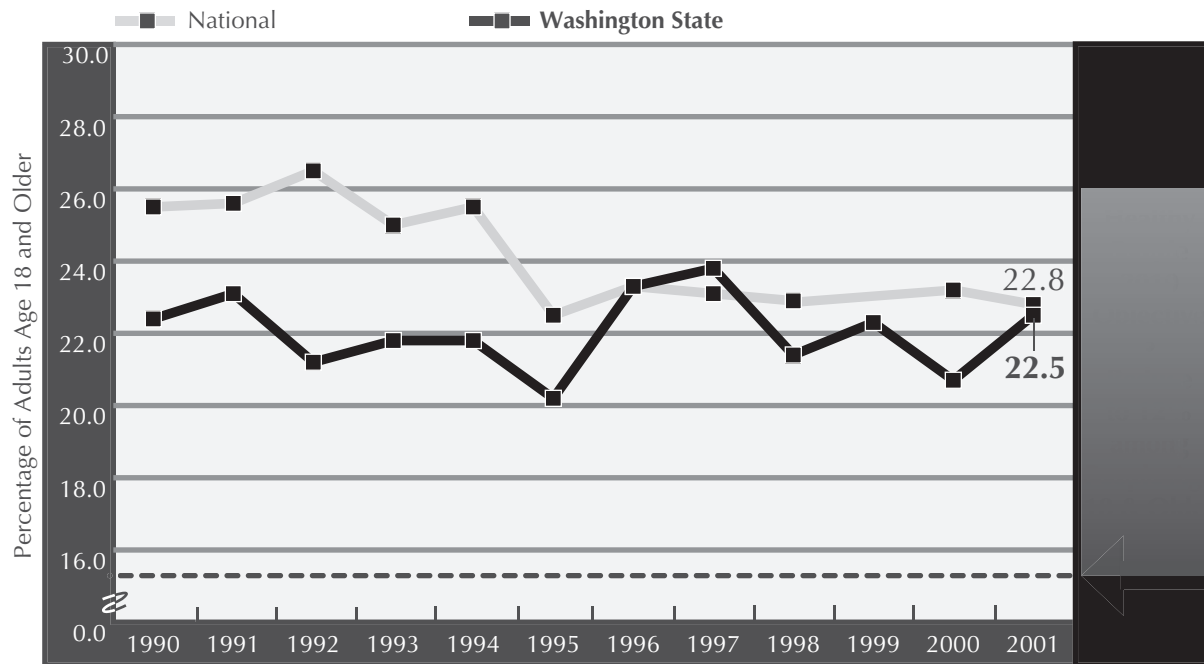
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**"Hard drugs" are any of the following substances used for non-medical purposes: sedatives, heroin, stimulants, hallucinogens, and other opiates.

Smoking Prevalence Among Adults in Washington State Parallels That of the Nation.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Tobacco use remains the leading cause of preventable death and disease in the United States, and is responsible for more than 430,000 deaths each year.¹ Since the release of the first Surgeon General's report on smoking and health, about ten million Americans have died from smoking-related diseases, including heart disease, lung cancer, emphysema, and other respiratory diseases.² *Healthy People 2010* sets a target objective to reduce tobacco smoking by adults ages 18 and older to 12%.

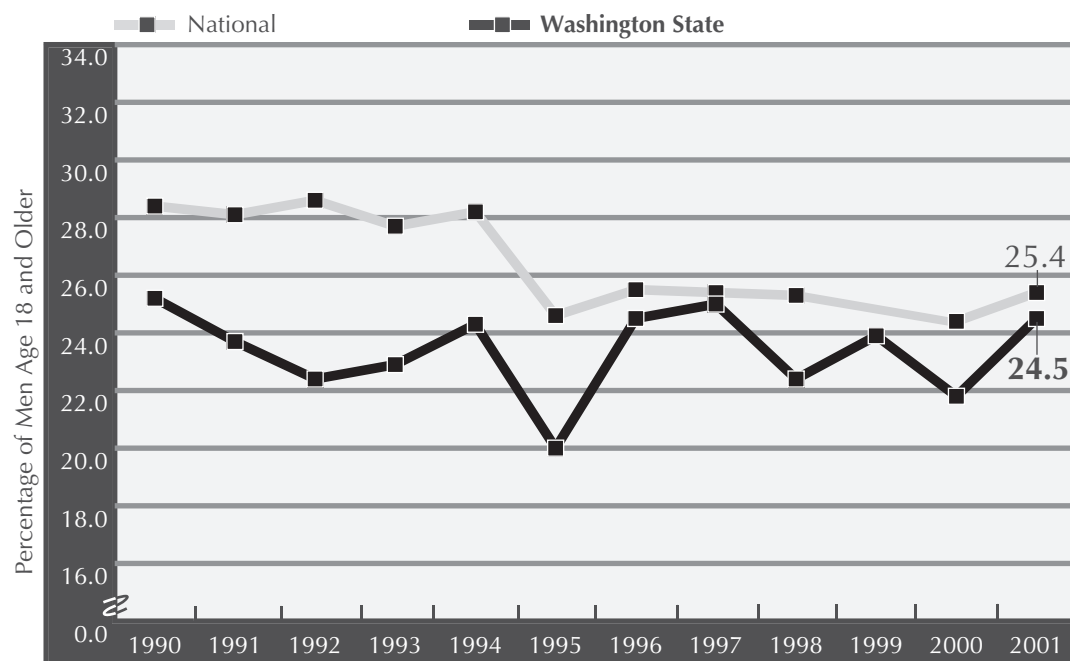
Smoking rates among adults in Washington States and nationwide remain virtually unchanged from a decade ago.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 27-3. Washington, DC: 2000.

² U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.



Smoking Prevalence Among Men in Washington State is Virtually Unchanged from a Decade Ago.



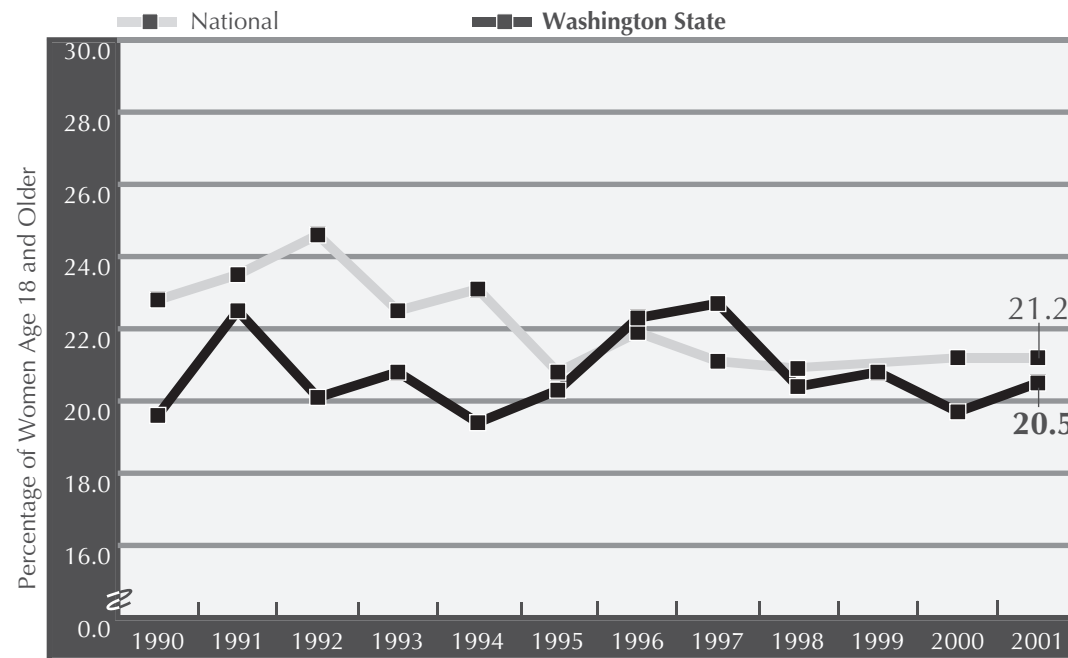
Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Smoking is closely associated with heart disease, cancer, emphysema, and other respiratory diseases.¹

This graph indicates that smoking prevalence among Washington men is similar to that among men nationally, and is little changed since 1990. Greater gains in reducing smoking prevalence were made in Washington State in previous decades.

¹ U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

Smoking Prevalence Among Women in Washington State is Little Changed from a Decade Ago.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Besides being linked with heart disease, lung cancer, emphysema, and other respiratory diseases¹, evidence is accumulating that maternal tobacco use is associated with mental retardation and birth defects such as oral clefts², and with Sudden Infant Death Syndrome.³

This graph indicates that smoking prevalence among Washington women parallels that among women nationally, and is little changed in the past decade.

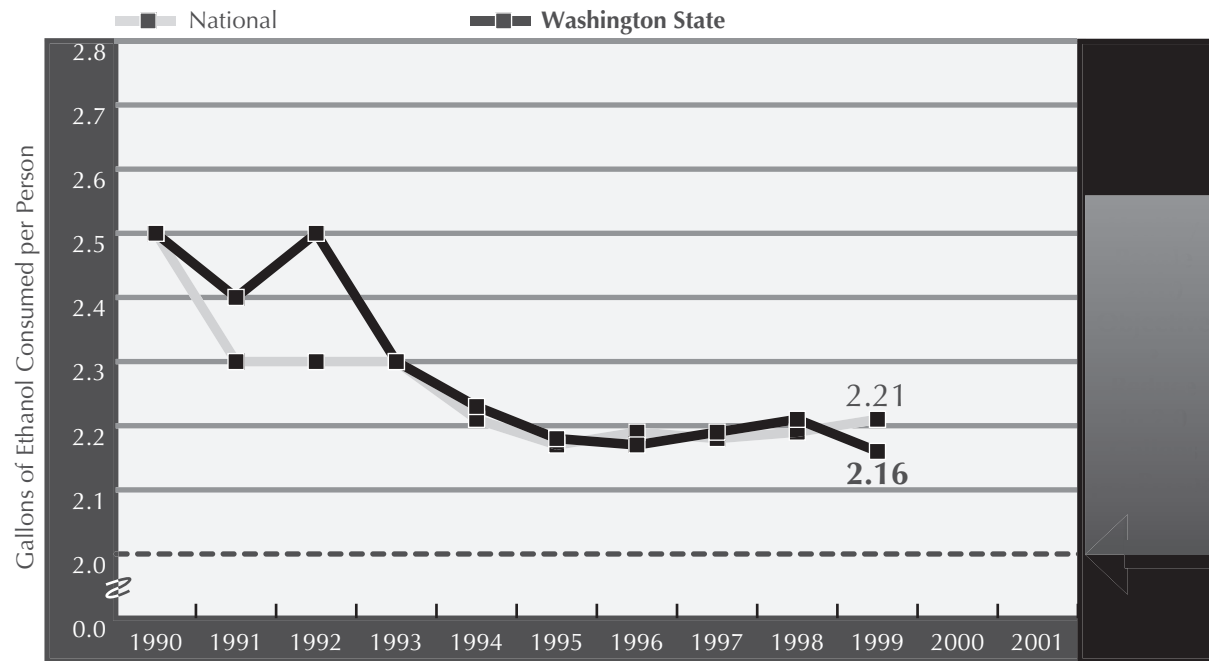
¹ U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 27-3. Washington, DC: 2000.

³ Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome," *Journal of the American Medical Association*, March 8, 1995.



Per Capita Alcohol Consumption in Washington State is Similar to That of the Rest of the Nation.

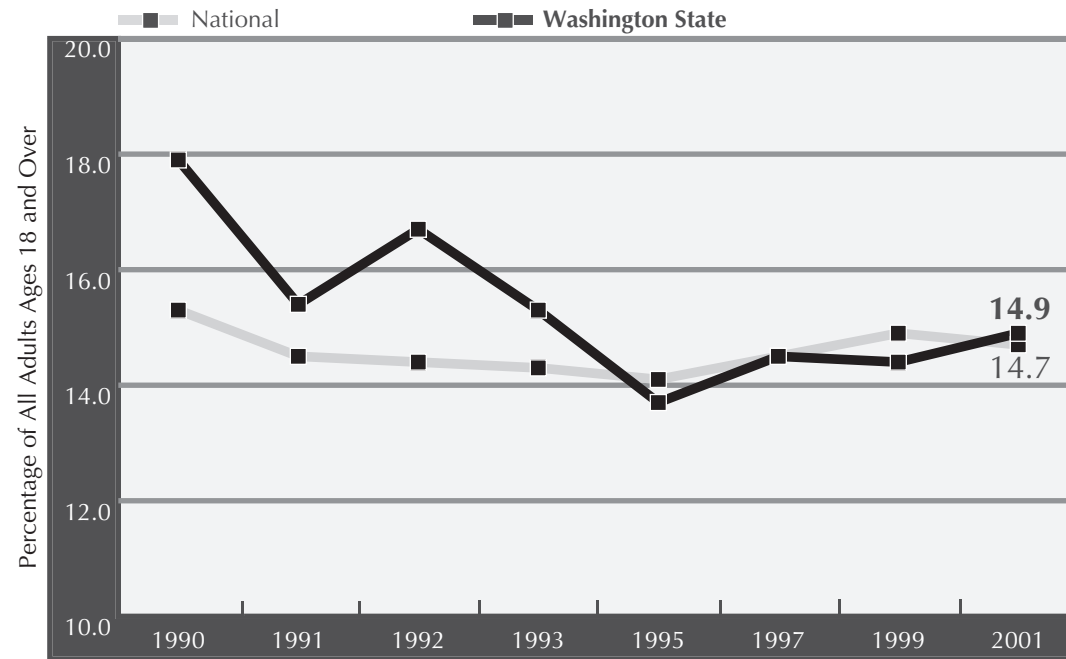


Source: National Institute on Alcohol Abuse and Alcoholism, *Per Capita Ethanol Consumption for States, Census Regions, and the United States, 1970-1999*.

State and national per capita consumption of alcohol (for all persons over age 14) has remained constant over the past six years, after falling for more than a decade. Per capita consumption is approaching the *Healthy People 2010* target objective. However, in 2002, almost one in five Washington 8th graders report having used alcohol in the past 30 days.¹

¹ Office of Superintendent of Public Instruction, *Washington State Survey of Adolescent Health Behaviors—2002*. Olympia, WA: 2003.

Binge Drinking Rates Among Washington State Adults are Similar to That of the Nation.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

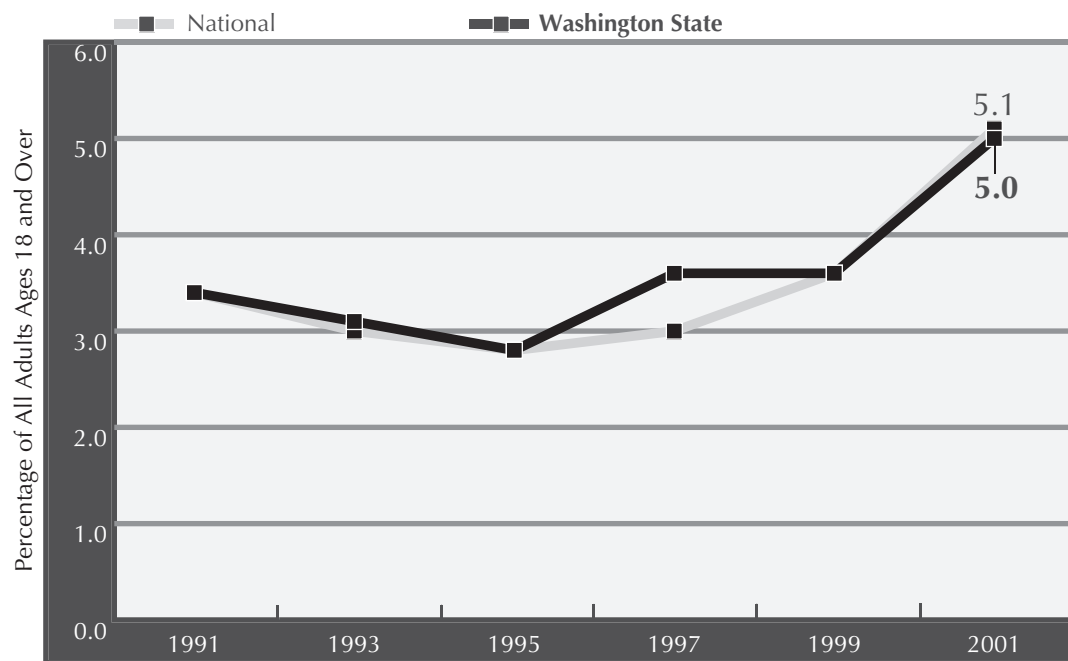
Binge drinking (defined as having five or more alcoholic drinks at one occasion, one or more times in the past month) is a particularly dangerous form of alcohol consumption, and is associated with traffic fatalities, accidents, drownings, emergency department admissions, and alcoholism. Males are twice as likely to binge drink as females. Binge drinking rates among high school seniors and college students are more than twice that of the adult population.¹

Binge drinking rates in Washington State and the nation are little changed from a decade ago.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-29. Washington, DC: 2000.



Chronic Drinking Rates Among Washington State Adults Appear to Be on the Rise.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Chronic drinking (defined as having had an average of two or more drinks per day per month) is associated with alcohol-related problems, as it may impair mental performance and physical coordination. It may also lead to alcohol dependency.¹

Chronic drinking among Washington State adults appears to be on the rise, and is at its highest point in more than a decade.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-33. Washington, DC: 2000.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

Crime

Violence

Family
Distress

The Problem: Substance Abuse Prevalence & Trends

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SUBSTANCE
ABUSE
IMPACT**

**Birth Defects/
Complications**

**Accident
Risks**

**Health
Consequences**

**Infectious
Diseases**

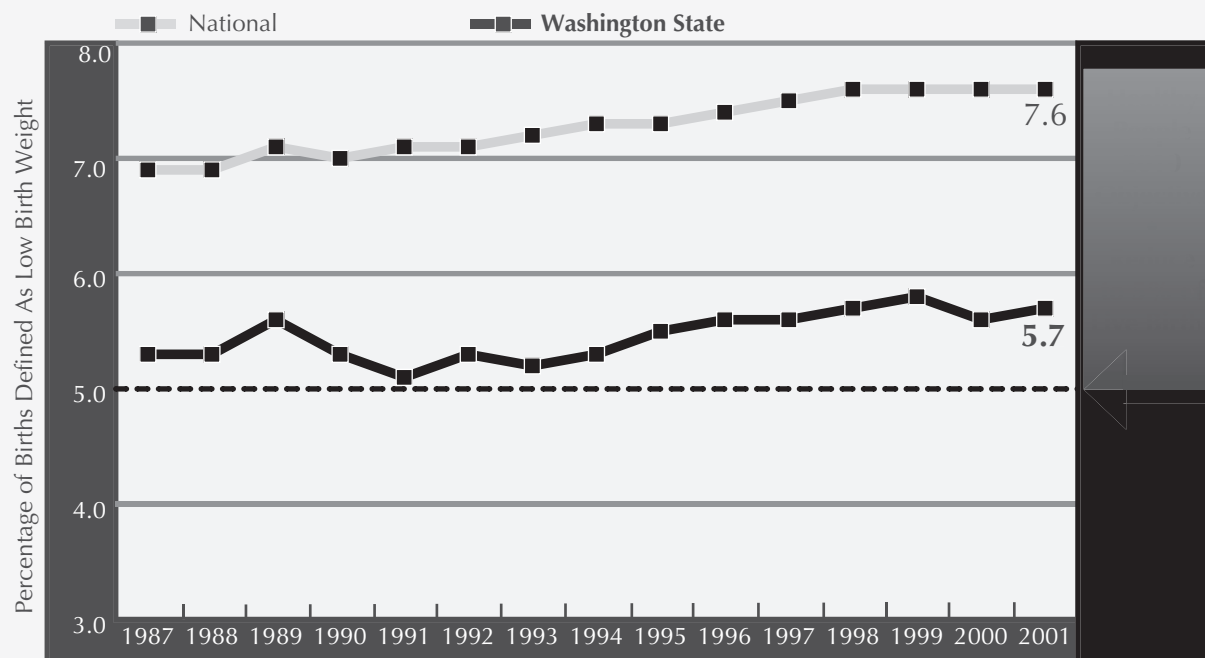
Crime

Violence

**Family
Distress**



A Lower Percentage of Low Birth Weight Babies are Born in Washington State than Nationally.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Smoking is associated with 20-30% of all low birth weight (LBW) births, as well as being the risk factor most closely associated with neonatal deaths.¹

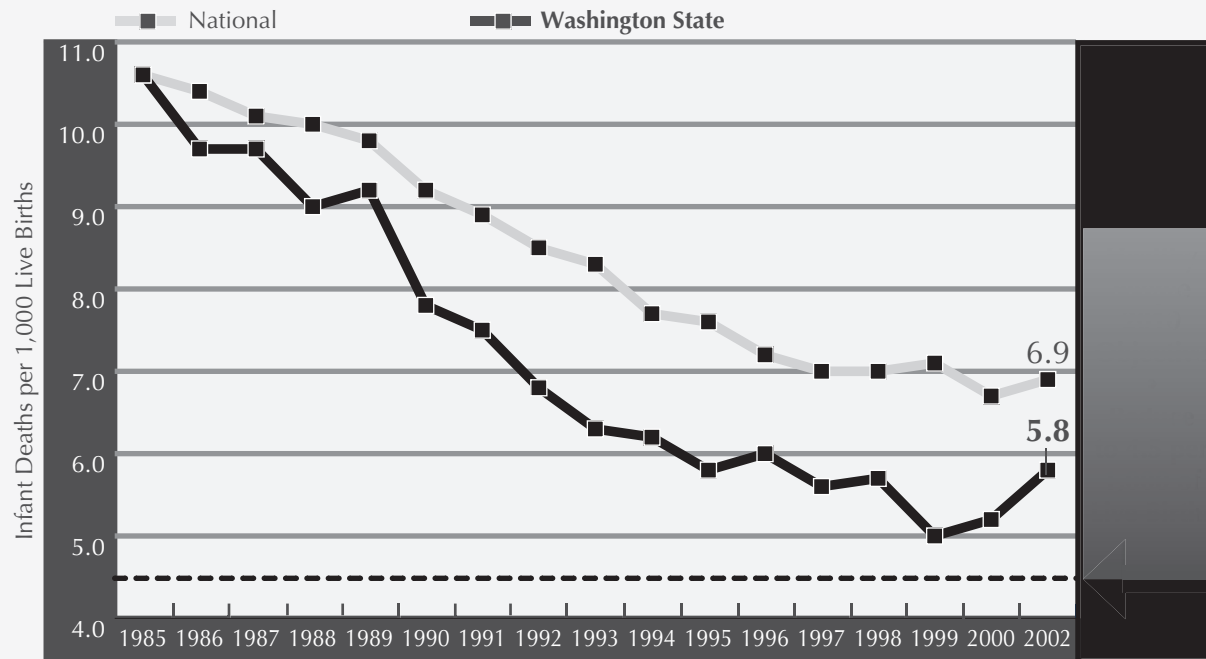
LBW infants are newborns weighing less than 2,500 grams (5 pounds, 8 ounces) and include those born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.² Two Washington studies reported fewer LBW births among substance-abusing women who received chemical dependency treatment during pregnancy.³

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC, 2000.

² Ibid.

³ Krohn, M. "Preliminary Findings for MOMS Project", *Focus*, 1993. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Shrager, L., Kenny F., and Cathon, L. *Substance Abuse Treatment for Female DASA Clients: Treatments, Birth Outcomes, and Demographic Profiles*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1993.

Washington State Has a Lower Infant Death Rate than the Nation, Though There Was a Significant Increase in 2001.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

There is a clear association between overall rates of alcohol use during pregnancy and infant death rates. Infant mortality rates for children born to mothers on Medicaid in Washington State and identified as substance abusers are more than twice as high as those for infants born to mothers on Medicaid not so identified.¹

Infant death rates represent the number of infants per thousand live births who die within their first year of life. Sudden Infant Death Syndrome (SIDS) accounts for nearly one-third of all infant deaths after the first month of life.² SIDS has been linked with passive smoking in the infant's environment and maternal smoking during the time period of breastfeeding.³

Washington State has had consistently lower infant death rates than the nation. Rates have been dropping for the past 15 years. Advances in medical technology, coupled with public education campaigns to ensure infants are put to sleep on their backs to lower SIDS risk, are primarily responsible for the downward trend. The statistics for 2001 represent a potential change in trend.

¹ First Steps Database, 1990-1997. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1999.

² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-1. Washington, DC, 2000.

³ Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome," *Journal of the American Medical Association*, March 8, 1995.

The Problem: Substance Abuse Prevalence & Trends

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Birth Defects/
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Accident
Risks

Health
Consequences

Infectious
Diseases

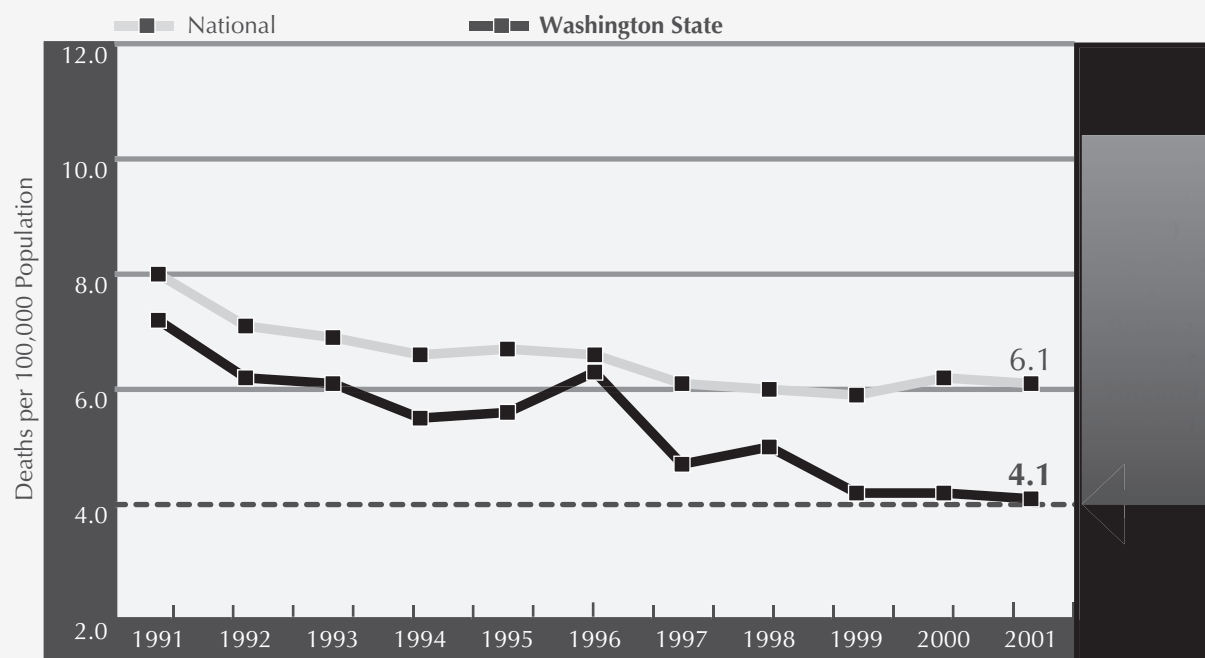
Crime

Violence

Family
Distress



New Driving-Under-the-Influence (DUI) Statutes in Washington State are Closely Associated with Lower Rates of Alcohol-Related Motor Vehicle Fatalities.



Source: National and state data from the Fatal Accident Reporting System, Washington Traffic Safety Commission.

Enhancements to Washington State's Driving-Under-the-Influence (DUI) statutes, including a lowering of the blood-alcohol concentration (BAC) necessary for a DUI determination from .10% BAC to .08% BAC, went into effect in 1999. Since then, the rate of alcohol-related motor vehicle traffic fatalities has dropped substantially.¹ Similar changes have not been demonstrated nationwide. Lower fatality rates are also associated with increased use of safety restraints, enforcement of minimum drinking age and zero tolerance laws.² They may also be associated with enforcement of lower speed limits. The alcohol-related fatality rate for youth is higher than for adults, but has dropped more than 50% since 1982, mostly as a result of enforcement of minimum drinking age laws.³

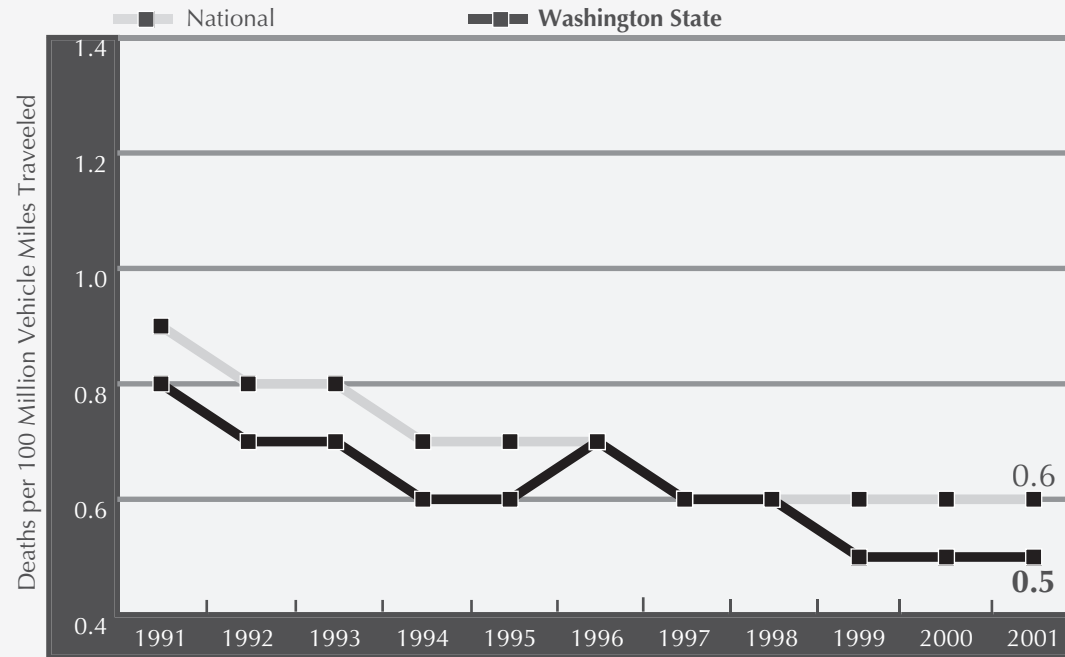
The number of alcohol-related motor vehicle fatalities in Washington State has declined from 361 in 1991 to 243 in 2001, a drop of almost 50%.

¹ Salzberg, Philip, and Anne Yamada. *Drunk Driving Trends in Washington State: Evaluation of the 1998 DUI Laws*. Olympia, WA: Traffic Research and Data Center, Washington State Traffic Safety Commission, 2002.

² Research and Development, National Center for Statistics & Analysis, National Highway Traffic Safety Administration. *Traffic Safety Facts 2000-Alcohol*. Washington, DC: U.S. Department of Transportation, 2001.

³ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-14. Washington, DC: 2000.

The Death Rate from Alcohol-Related Motor Vehicle Crashes per 100 Million Miles Traveled Now Stands at All-Time Lows.

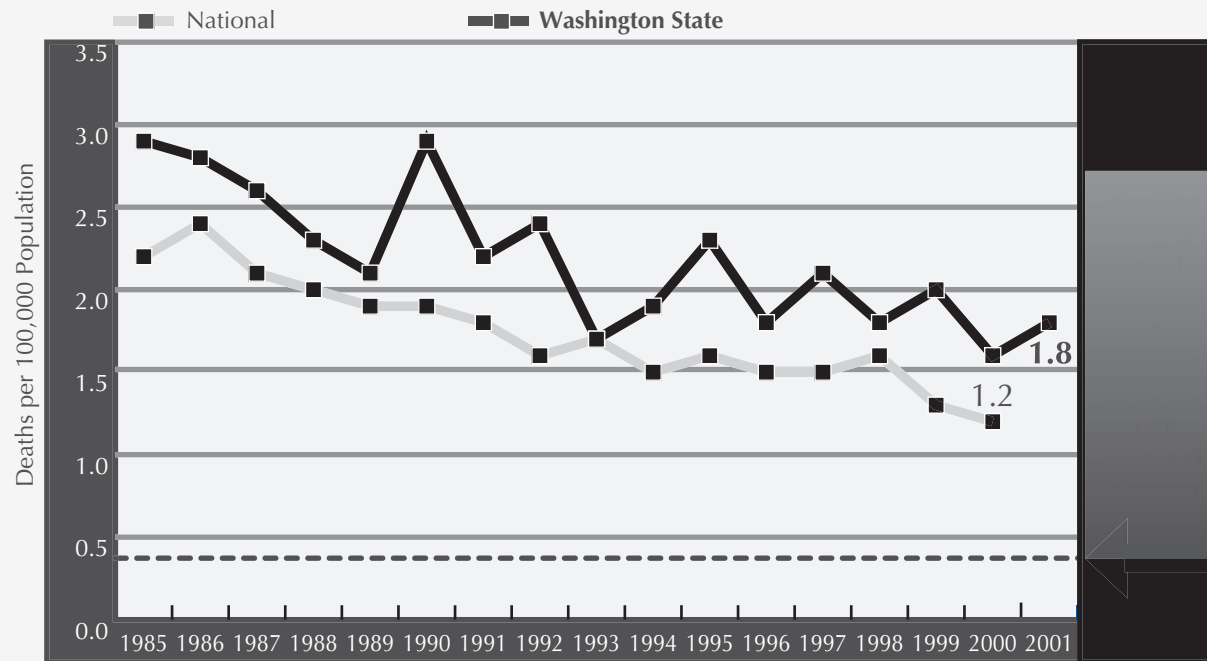


Source: National data from the National Center for Statistics & Analysis, National Highway Safety Traffic Administration. State data from the Fatality Analysis Reporting System, Washington Traffic Safety Commission.

In 2001, the motor vehicle fatality rate per 100,000 vehicle miles driven reached historic lows, both nationally and in Washington State. Lower fatality rates are associated with the increased use of safety restraints, enforcement of minimum drinking age and zero tolerance laws, and statutes setting lower blood alcohol concentration (BAC) standards for driving-under-the-influence.¹



Washington State Has a Higher Rate of Deaths Due to Drowning than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

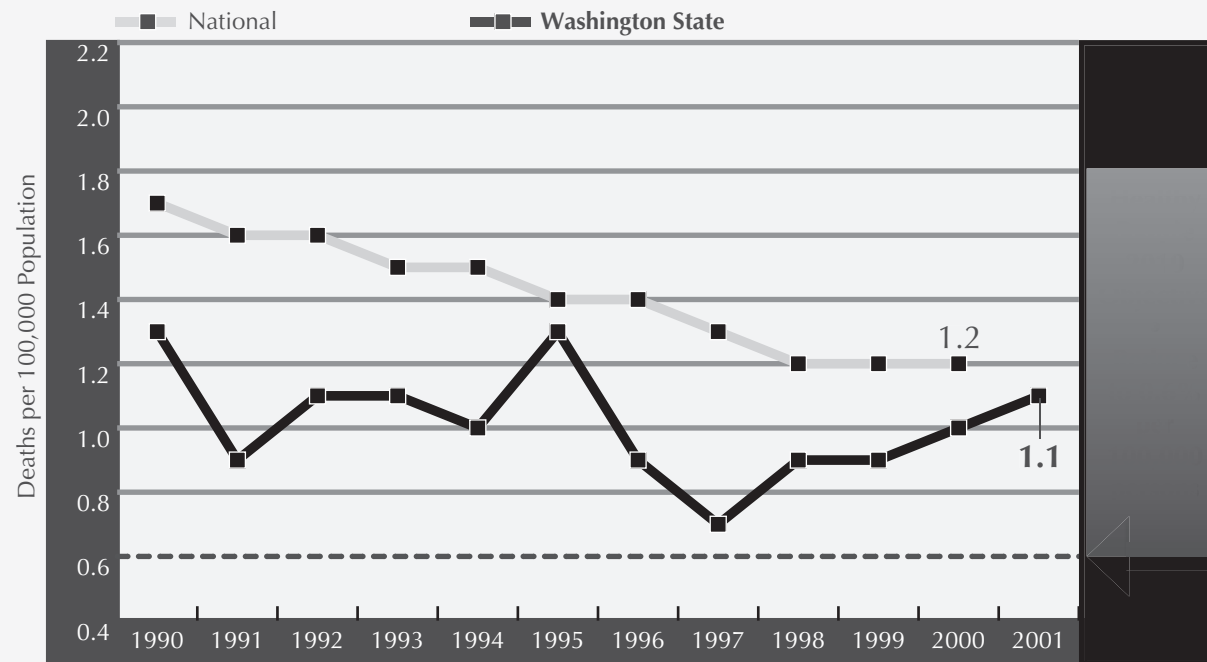
Alcohol is involved in approximately 50% of deaths associated with water recreation.¹

This graph indicates that the rate of drowning deaths in Washington State has been consistently higher than the national rate. There were 107 drowning deaths in Washington State in 2001, up from 92 in 2000. Nationally, drowning is the second leading cause of injury-related deaths for children and youth ages 1-19.²

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 15-40. Washington, DC: 2000.

² Ibid.

The Rate of Deaths Due to Residential Fires in Washington State is Rising.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

This graph indicates that the rate of deaths due to residential fires in Washington State is on the rise. There were 63 such deaths in 2001, as compared with 39 in 1997.

Fires are the second leading cause of unintentional injury death among children. Compared to the total population, children ages four and under have a fire death rate more than twice the national average. Two-thirds of fire-related deaths and injuries among children under age five occur in homes without working smoke alarms.¹

The Problem: Substance Abuse Prevalence & Trends

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Risks

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Consequences

Infectious
Diseases

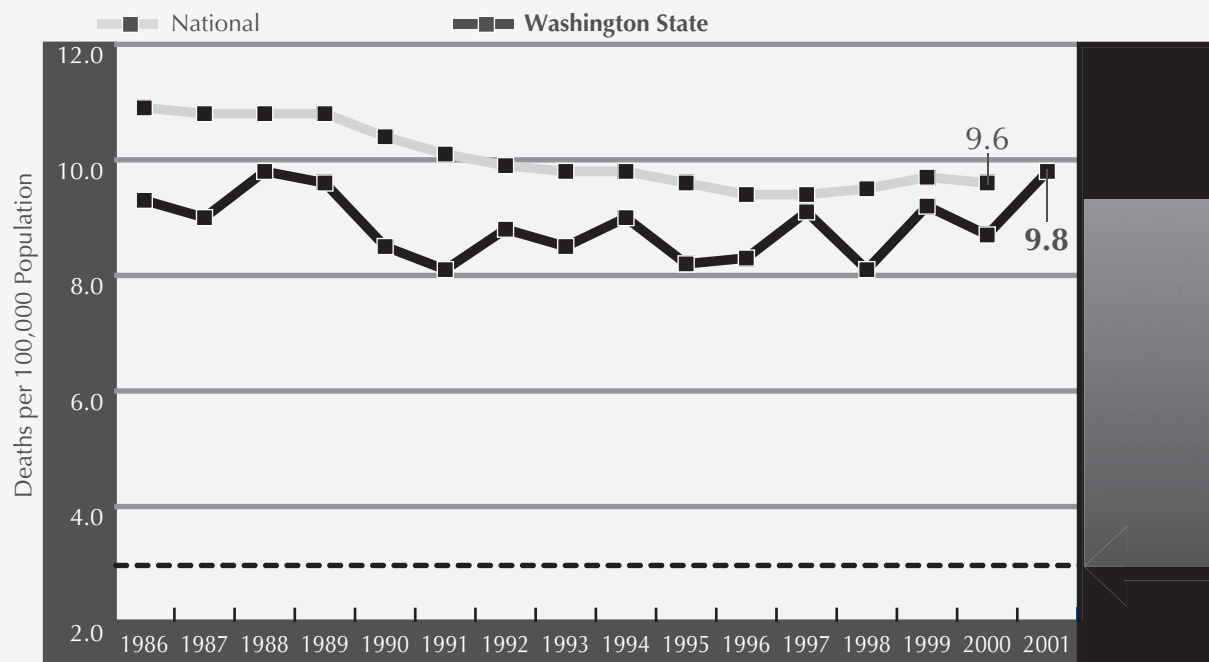
Crime

Violence

Family
Distress



Deaths in Washington State Due to Chronic Liver Disease and Cirrhosis are at Their Highest Rate in a Decade.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Cirrhosis occurs when healthy liver tissue is replaced with scarred tissue until the liver is unable to function effectively. Sustained heavy alcohol consumption is the leading cause of cirrhosis.¹

For the first time in a decade, the death rate due to chronic liver disease in Washington State appears to match the national rate.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-16. Washington, DC, 2000.

The Drug-Induced Death Rate in Washington State is More than Double What It Was in 1991.



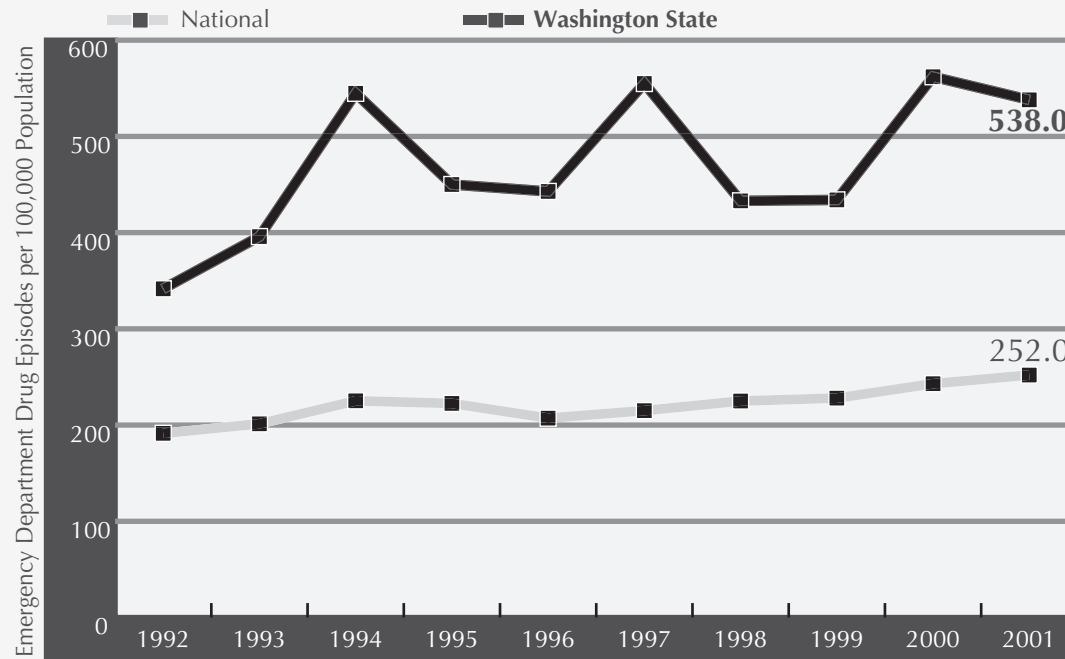
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Drug-related death data provide a direct indication of the high human and social costs of drug use. Causes of death classified as drug-related include drug psychosis, drug dependence, suicide, and intentional and unintentional poisoning resulting from illicit drug use.

This graph indicates that Washington State has had a consistently higher drug-induced death rate than the nation. This rate is more than twice as high as it was in 1991.



The Seattle Metropolitan Area Has a Higher Rate of Drug-Related Emergency Room Visits than the Nation.

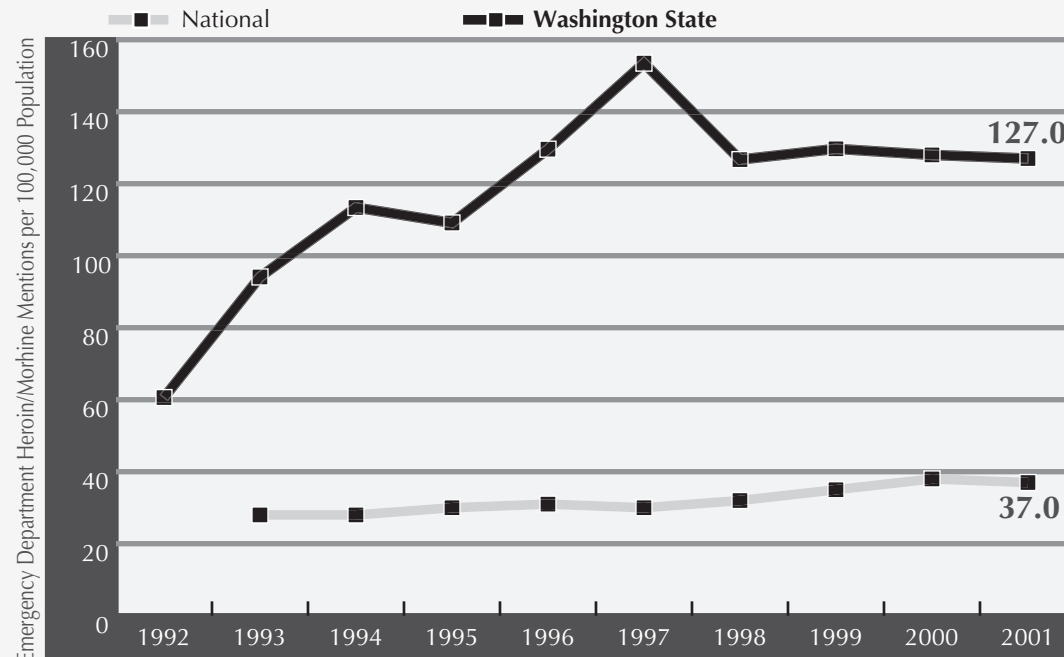


Source: Office of Applied Studies, Substance Abuse Mental Health Services Administration, Drug Abuse Warning Network (DAWN).

This graph indicates that the Seattle metropolitan area (the only area in Washington State for which this information is available) has a higher rate than the nation for drug-related emergency room visits.

The federal Drug Abuse Warning Network defines an emergency department visit as drug-related whenever the visit is a result of the non-medical use of a drug. Non-medical drug use includes use of illicit drugs, use of prescription drugs in a manner inconsistent with accepted medical practice, and the use of over-the-counter drugs contrary to approved labeling.

Rates of Emergency Department Mentions of Heroin/Morphine in Seattle-King County Have Stabilized Since 1997.



Source: Office of Applied Studies, Substance Abuse Mental Health Services Administration, Drug Abuse Warning Network (DAWN).

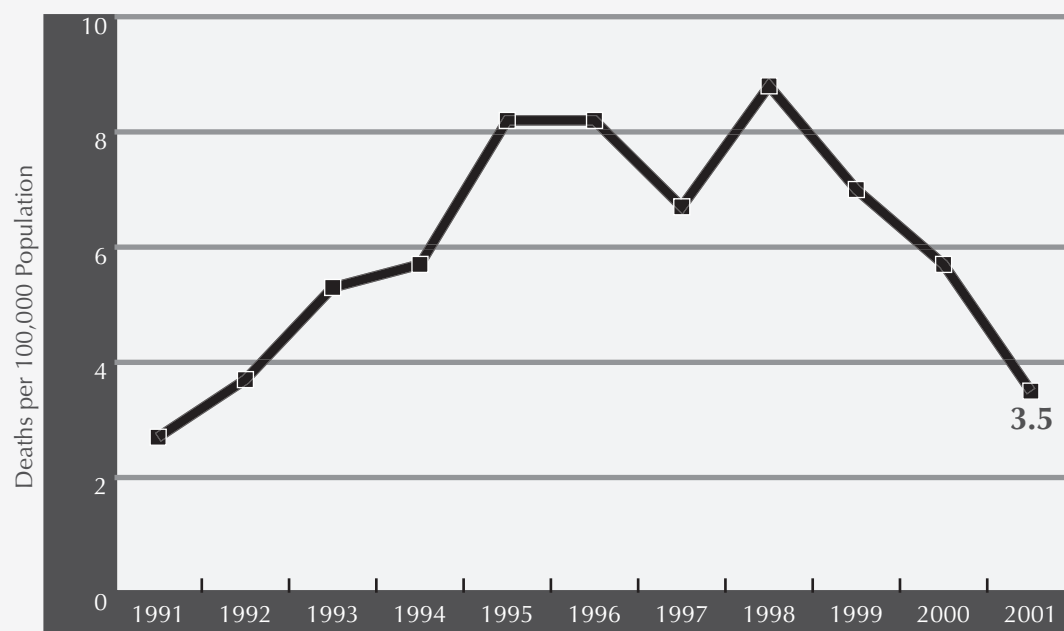
This graph indicates that after doubling between 1992 and 1997, the steep rise in emergency department mentions of heroin/morphine in Seattle-King County has leveled off. At the same time, there has been a steep decline in the number and rate of heroin-related deaths.

Some of this leveling off may be due to expanded treatment capacity for individuals with heroin addiction. However, there are still substantial waiting lists – with waits sometimes for years – for publicly funded opiate substitution (methadone) treatment in King County, and throughout the state.¹ Within King County alone, there is currently a waiting list of more than 500 people who have requested treatment but are unable to access it because of limited treatment capacity and/or funding limitations.²

¹ King County Bar Association. "Statement on Methadone and Waiting Lists – November 2002."

² Heroin Task Force Report. *Confronting the Problem of Heroin Abuse in Seattle and King County*. Seattle, WA: Public Health—Seattle & King County, August 2001.

Rates of Heroin-Related Deaths in Seattle-King County Have Declined Substantially Since 1998.



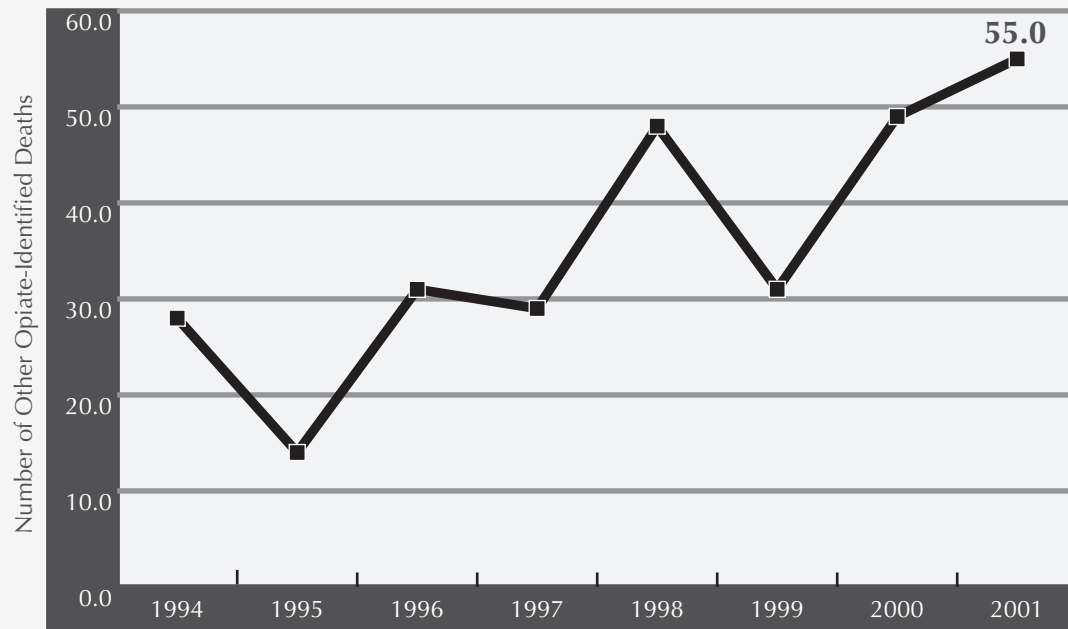
Source: King County Medical Examiner.

This graph indicates that while the rate of heroin-related deaths in Seattle-King County increased fourfold from 1991-1998, they have declined by more than 57% since then, from a total of 143 deaths in 1998 to 61 in 2001.

Much of this decline is likely due to public health measures adopted by city and county governments to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. They have also provided preventive and limited substance abuse treatment services in the local criminal justice system, and expanded the availability of drug-free housing for individuals in recovery. Recently, however, new treatment admissions have also declined, probably because effective treatment is resulting in longer treatment stays, and correspondingly fewer open treatment slots.⁸

⁸ Banta-Green, Caleb et al. "Recent Drug Abuse Trends in the Seattle-King County Area," *Epidemiologic Trends in Drug Abuse*, June 2002.

The Number of Other Opiates* Identified in Drug-Caused Deaths in King County has Doubled Since 1994.



Source: King County Medical Examiner.

The use of other opiates in pain management has risen substantially in recent years. As the population ages, and as medical science is better able to manage conditions which previously would have resulted in more rapid death, the use of pain management medications plays an important role in increasing quality of life.

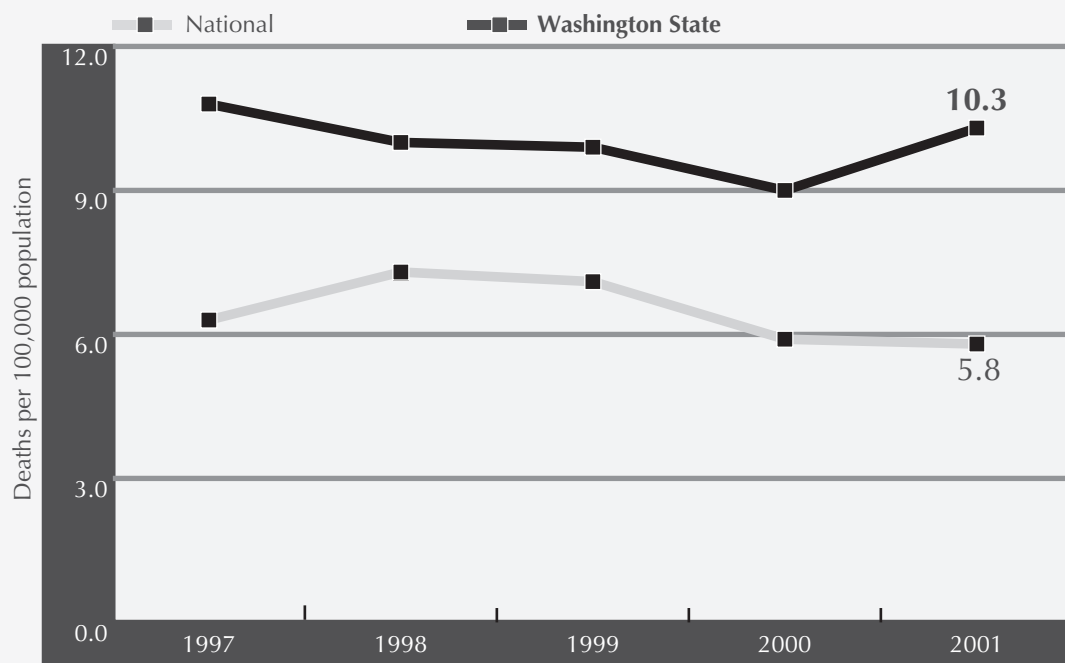
The expanded prescriptive use of other opiates, however, creates new opportunities for diversion and illicit use. According to the local office of the federal Drug Enforcement Agency, hydrocodone is the most commonly diverted other opiate. There has been a significant increase in mentions of oxycodone among drug-related deaths, from four in 1999 to 18 in 2001. OxyContin, illicit use of which has become epidemic in other parts of the U.S., is a time-release formulation of oxycodone.¹

* Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene. There are more mentions than deaths because some individuals had multiple other opiates detected at time of death.

¹ Banta-Green, Caleb et al. "Recent Drug Abuse Trends in the Seattle-King County Area," *Epidemiologic Trends in Drug Abuse*, June 2002.



Washington State Has a Higher Alcohol-Induced Death Rate than the Nation.



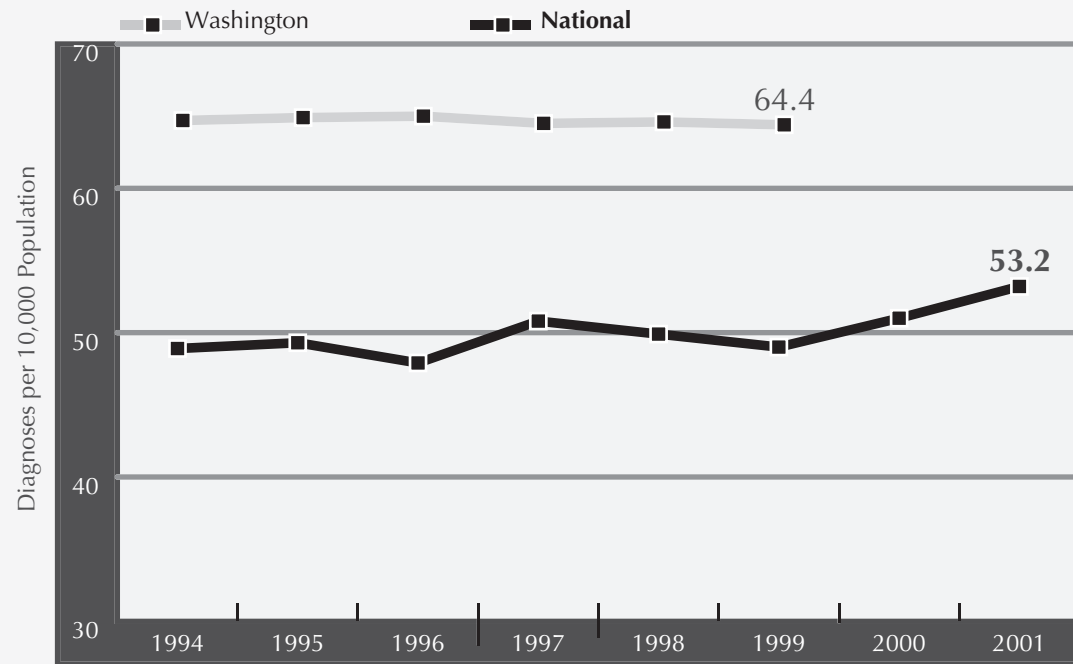
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol-related death data provide a direct indication of high human and social costs of alcohol use. Long-term heavy drinking increases risks for high blood pressure, heart rhythm irregularities (arrhythmias) and heart muscle disorders (cardiomyopathy), and stroke. It increases risks for certain forms of cancer, especially esophagus, mouth, throat, and larynx, for cirrhosis and other liver disorders, and worsens outcomes for individuals with hepatitis C. It is also linked with death from traffic crashes, falls, fires, and drowning, and is associated with homicide, suicide, domestic violence, and child abuse.¹

This graph indicates that Washington State has had a consistently higher alcohol-induced death rate than the nation. It should also be noted that the alcohol-induced death rate in Washington State is consistently higher than the drug-induced death rate.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-4. Washington, DC, 2000.

The Rate of Alcohol-Related Diagnosis Among Acute Hospital Discharges Has Remained Relatively Static.



Source: National data from Alcohol Epidemiology Data System, Division of Biometry and Epidemiology, National Institute, "Surveillance Report #58 (Revised): Trends in Alcohol-Related Morbidity Among Short-Stay Community Hospital Discharges, United States, 1979-99". State data from the Comprehensive Hospital Abstract Report System (CHARS), Washington State Department of Health.

Alcohol-related diagnoses are defined as discharges from acute care hospitals associated with primary alcohol-related conditions such as alcohol psychoses, alcohol dependence syndrome, nondependent abuse of alcohol, and chronic liver disease and cirrhosis. They do not include alcohol-related trauma such as injuries from motor vehicle crashes, or discharges associated with maternity stays. There were 24,637 primary alcohol-related diagnoses discharges from Washington State hospitals in 2001.



The Lung Cancer Death Rate in Washington State Has Risen in the Past Five Years.



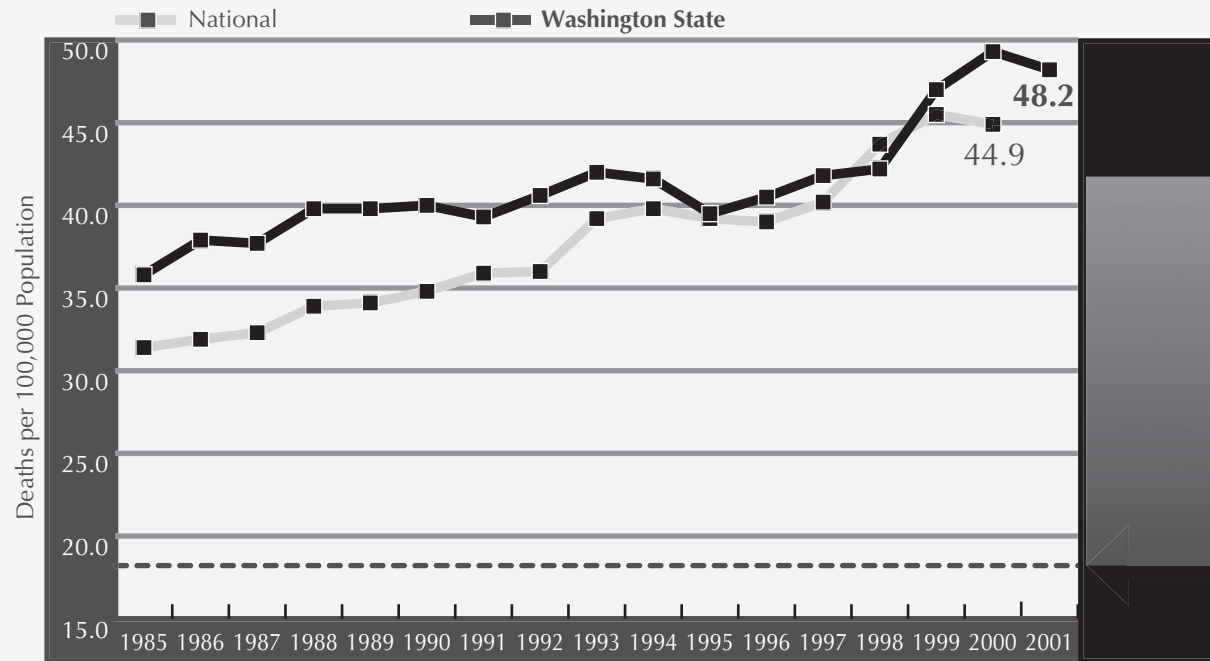
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

The vast majority of lung cancer cases are attributable to cigarette smoking, accounting for 68-78% of lung cancer deaths among females, and 88-91% of deaths among males. Smoking cessation decreases the risk of lung cancer to 30-50% of that of continuing smokers after ten years of abstinence.¹

This graph indicates that the death rate from lung cancer in Washington State has risen in the past five years. Lung cancer is the most common category of cancer mortality in the U.S.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 3-12, Washington, DC, 2000.

The Death Rate in Washington State from Chronic Lower Respiratory Disease is Rising.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Chronic lower respiratory disease (formerly known as chronic obstructive pulmonary disease) occurs most often in people over age 65. Between 80-90% of cases are attributable to cigarette smoking.¹

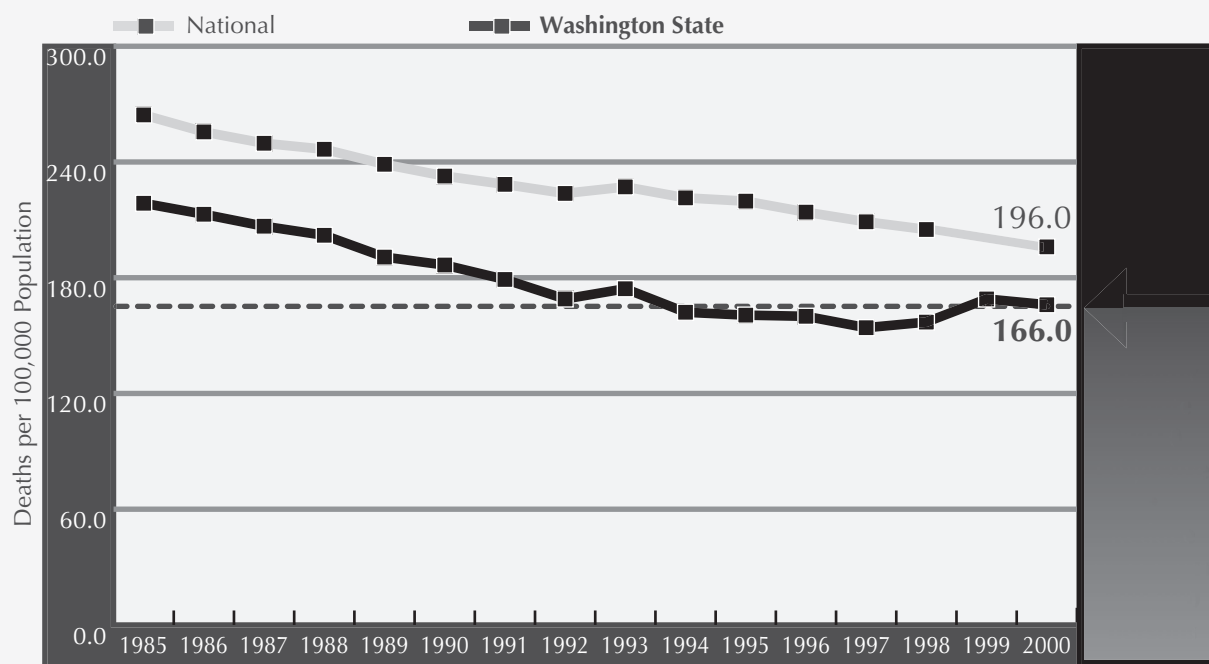
This graph indicates that the mortality rate from chronic lower respiratory disease both in Washington State and nationally has been rising. It is now the fourth leading cause of death in Washington State. Chronic lower respiratory disease includes chronic bronchitis and emphysema, both of which are characterized by irreversible airflow obstruction. Both conditions often exist together.²

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 24-8. Washington, DC, 2000.

² *Ibid.*



The Coronary Heart Disease Death Rate in Washington State is Lower than the Nation.



Source: National and state data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention.

Heart disease is the leading cause of mortality in the U.S., and coronary heart disease accounts for the largest portion of heart disease deaths. About 12 million Americans have coronary heart disease. Prevention strategies include reducing high blood cholesterol, high blood pressure, obesity and excessive weight gain, and cigarette smoking, as well as increasing amounts of physical activity.¹

This graph indicates that the death rate from coronary heart disease in Washington State is consistently lower than the nation's, and is close to the *Healthy People 2010* target objective.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 12-6. Washington, DC, 2000.

The Problem: Substance Abuse Prevalence & Trends

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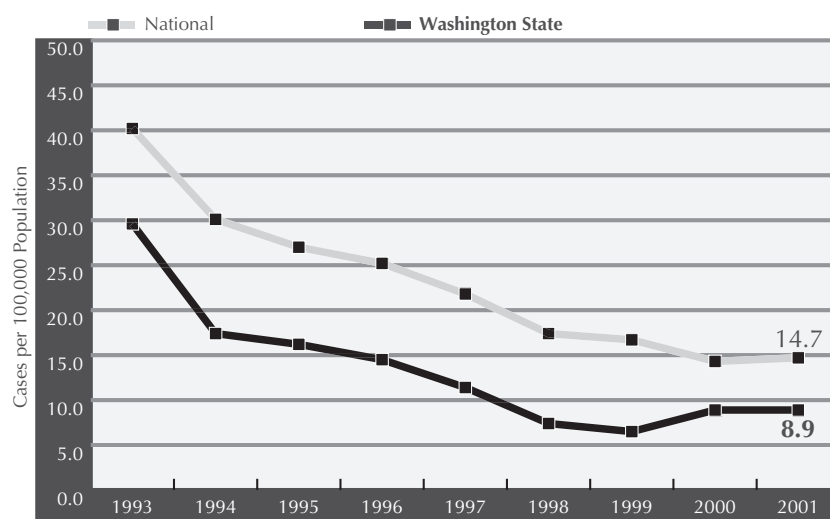
Crime

Violence

Family
Distress



The Reported AIDS Case Rate in Washington State is Lower than the Nation.*



Source: National and state data from the Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report – December 2001*, 13(2).

From January 1982 through December 2002, 10,384 AIDS (Acquired Immune Deficiency Syndrome) cases were reported in Washington State, and there were 5,695 deaths from the disease. There are currently 4,689 Washington residents living with AIDS. Through 2002, 18% of AIDS cases in Washington State were traceable to possible exposure from injection drug use, substantially lower than the percentage of cases attributed to injection drug use nationally.¹ Studies have shown that cities that implemented needle exchange programs early in the AIDS epidemic – such as Seattle and Tacoma – have much lower infection rates among injection drug users (IDUs).

This graph indicates that the reported AIDS case rate in Washington is consistently lower than the nation's. Since 1993, the AIDS case rate has generally been in decline, reflecting the effectiveness of new treatments in preventing HIV (human immunodeficiency virus) infection from progressing to AIDS. However, the recent increase in the case rate in Washington State likely reflects the growing failure of anti-retroviral medications to work over sustained periods of time, as well as larger number of individuals seeking treatment.² The AIDS case rate in Seattle rose from 11.8 per 100,000 population in 2000 to 14.3 per 100,000 in 2001.³

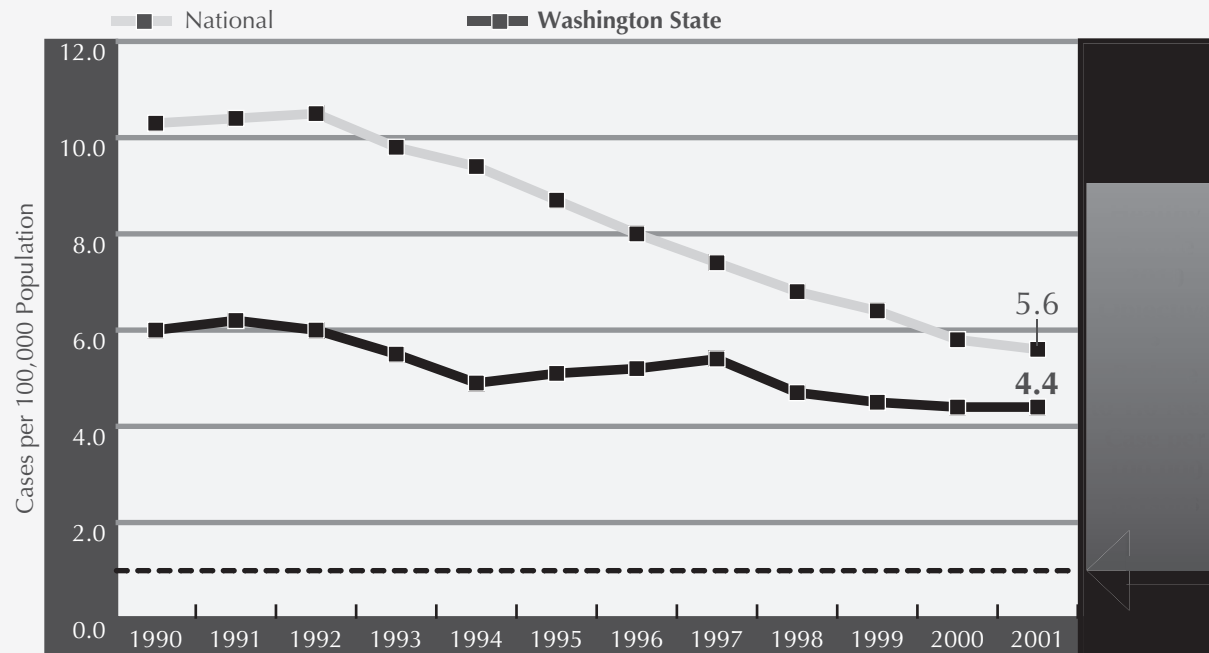
*Case counts are provisional; reporting is considered incomplete for several years.

¹ Office of HIV Prevention and Education, Washington State Department of Health, 2002.

² Infectious Disease and Reproductive Health Unit, Washington State Department of Health, 2002.

³ Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report – December 2001*, 13(2).

Washington State Has a Lower Rate of New Tuberculosis Cases than the Nation.



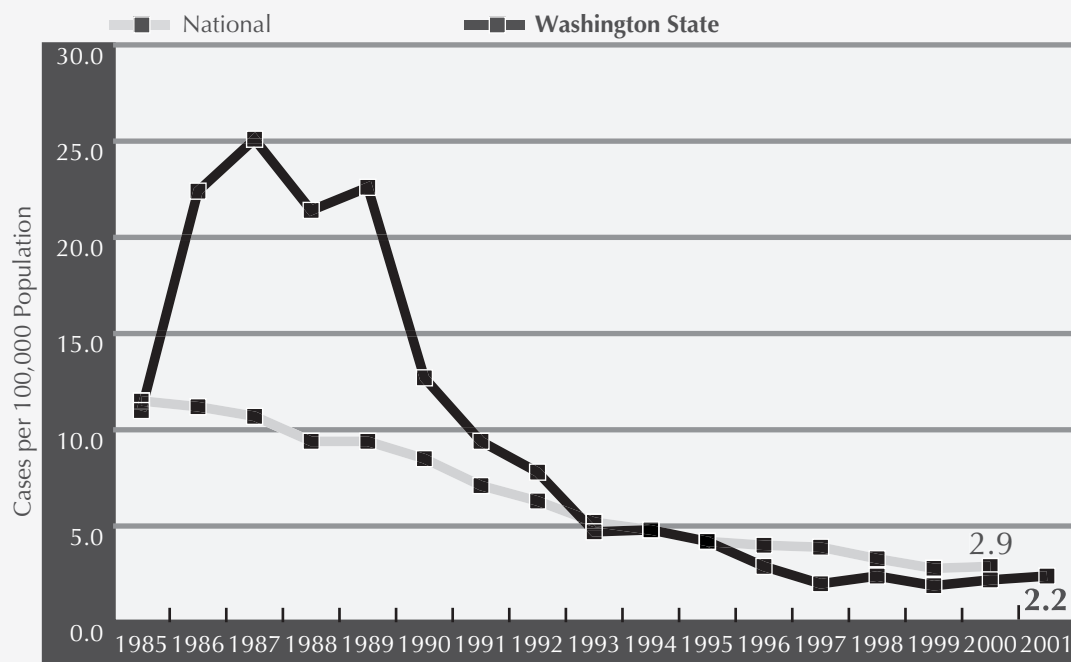
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from Assessment Unit – Infectious Disease and Reproductive Health, Washington State Department of Health.

Multiple risk factors, including poverty, homelessness, substance abuse, gaps in health care infrastructure, and the human immunodeficiency virus (HIV) epidemic, are associated with new tuberculosis cases. Assuring that patients with active tuberculosis infection complete curative therapy early is essential to curbing the disease's spread. Washington State has adopted treatment provider regulations to screen all chemical dependency patients to help prevent and control the spread of the disease.

This graph indicates that Washington has had a consistently lower tuberculosis rate than the nation. After a national and state resurgence in the early 1990s, the tuberculosis epidemic appears to have receded.



The Rate of Acute Hepatitis B in Washington State Has Declined in the Past Decade.



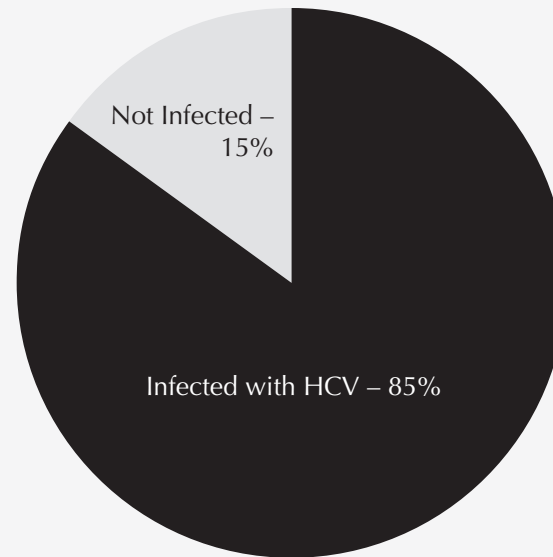
Source: National Data from the Epidemiology Program Office, National Notifiable Disease Surveillance System, Centers for Disease Control and Prevention. State data from Washington State Department of Health, *EpiTrends* 7(1), January 2002.

Injection drug use is a major risk factor for hepatitis B infection. Most cases occur in young adult risk groups, including persons with a history of multiple sex partners, men who have sex with men, injection drug users, incarcerated persons, and household and sex contacts of infected partners.¹

This graph indicates that the rate for acute hepatitis B cases in Washington State has declined steadily over the past decade (only acute cases are reportable in Washington). Hepatitis B is a serious disease that attacks the liver and is associated with cirrhosis, liver cancer, and liver failure. It is transmitted through blood, blood products, and sexual fluids. The hepatitis B virus (HBV) may be carried chronically without sign of infection, and transmitted perinatally. There is now a routine childhood vaccination for HBV.

¹ U. S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 14-15. Washington, DC, 2000.

Some 85% of Injection Drug Users in King County are Infected with Hepatitis C Virus (HCV)



Source: Community Epidemiology Work Group, National Institute on Drug Abuse, National Institutes of Health, *Recent Drug Trends in the Seattle-King County Area*, June 2001.

Of the 10-15,000 injection drug users (IDUs) in Seattle-King County, 85% are infected with hepatitis C virus (HCV). Recent incidence studies indicate that 21% of non-infected Seattle-area IDUs acquire HCV each year.¹ New research indicates that HCV may paradoxically increase methadone dose requirements for those receiving opiate substitution treatment.²

HCV is the most common chronic bloodborne viral infection in the U.S. It is most commonly transmitted through repeated exposures to blood. Most new cases occur among adults ages 20-39.

The number of acute cases of hepatitis C, both in Washington State and nationally, remains low, at or below one case per 100,000 people. However, chronic HCV affects an estimated four million people in the U.S.³ and causes an estimated 8,000-10,000 deaths each year from cirrhosis and liver cancer.⁴ It is the leading reason for liver transplantation in the U.S. Even moderate alcohol use is known to exacerbate liver injury resulting from HCV.

¹ Community Epidemiology Work Group. *Recent Drug Trends in the Seattle-King County Area*, June 2001. Bethesda, MD: National Institute on Drug Abuse, National Institutes of Health.

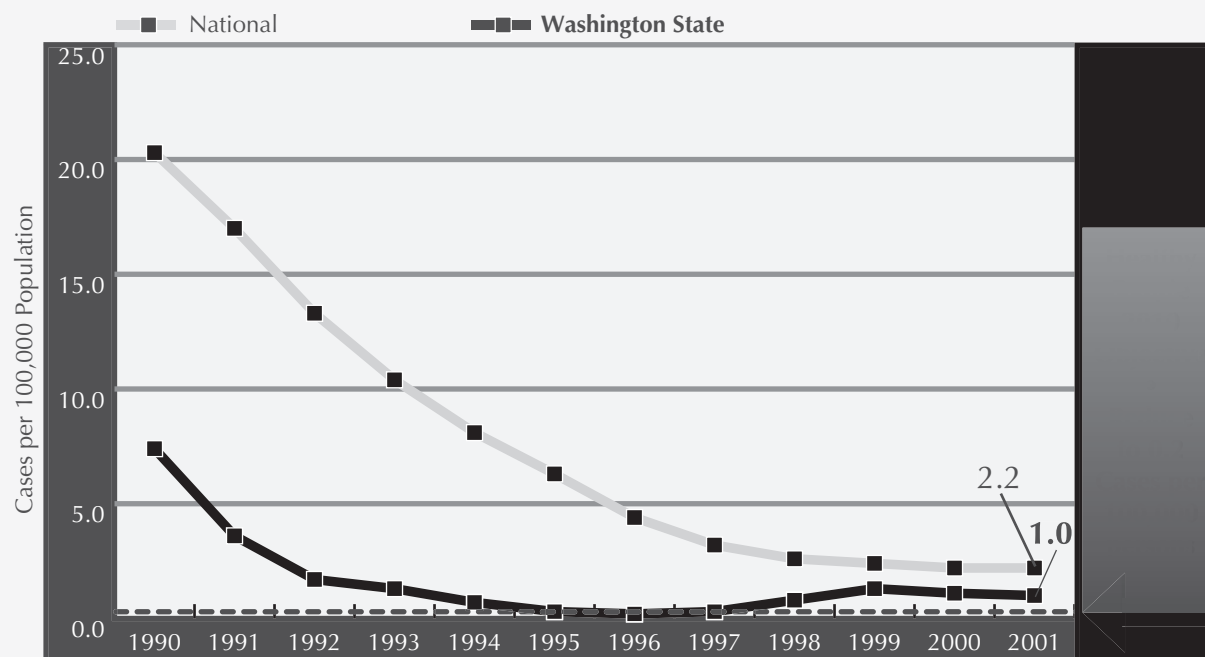
² "Clinical Concepts - HCV Paradoxically Increases Methadone Dose Requirement," *Addiction Treatment Forum* 9(4), Fall 2000.

³ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 14-24. Washington, DC, 2000.

⁴ Centers for Disease Control and Prevention. "Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease," *Morbidity and Mortality Weekly* 47(RR-10), October 1998.



While Lower than a Decade Ago, Washington State Has Experienced an Increase in the Rate of Primary and Secondary Syphilis.



Source: National data from STD Surveillance System, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. State data from STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health, *Sexually Transmitted Disease Morbidity, 2001– Washington State*.

The spread of sexually transmitted diseases (STDs), including syphilis, is often linked to the use of alcohol and other drugs. The introduction of new illicit substance use into a community often can substantially alter sexual behavior in high-risk sexual networks. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.¹

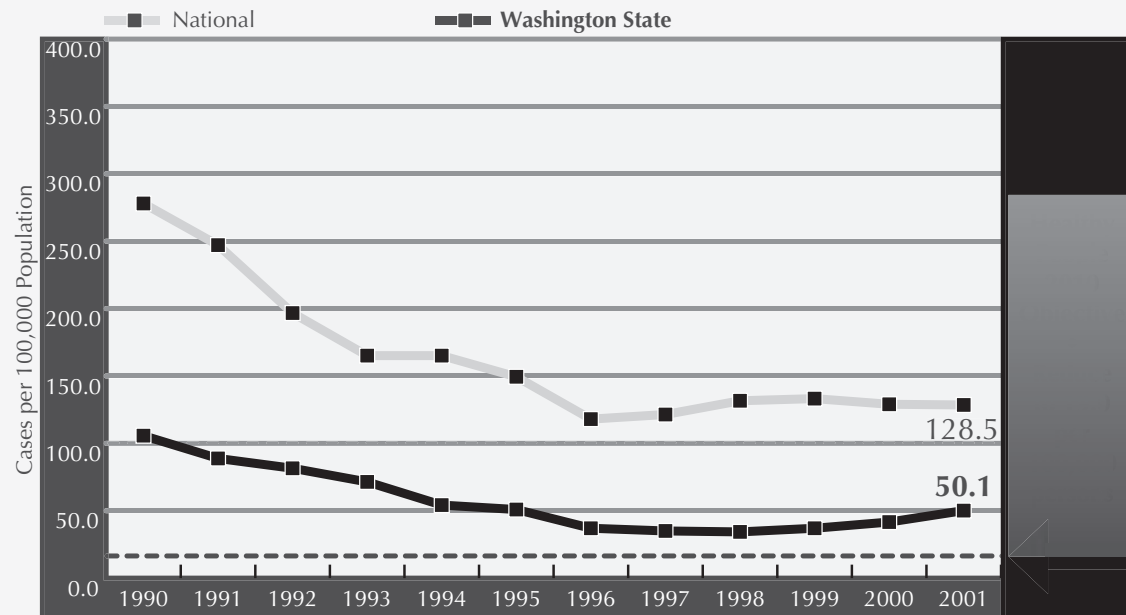
From a low of nine cases in 1996, Washington State has experienced a substantial increase in the number of primary and secondary (P&S) syphilis cases. There were 57 cases in 2001, 41 of them in King County. Transmission seems to be centered among men having sex with men², and may be associated with substance abuse, notably methamphetamine and inhaled nitrites.³ Counts of P&S syphilis cases may understate the problem, as cases are often diagnosed after they have gone beyond the primary and secondary stages and become latent.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC, 2000.

² STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health, *Sexually Transmitted Disease Morbidity, 2001– Washington State*. Olympia, WA, 2002.

³ Public Health – Seattle & King County. *Screening Guidelines for Men Who Have Sex with Men (MSM)*. Seattle, WA, 2001.

Gonorrhea Rates in Washington State Have Increased More than 50% Since 1998.



Source: National data from STD Surveillance System, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. State data from STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health, *Sexually Transmitted Disease Morbidity, 2001-- Washington State*.

The spread of sexually transmitted diseases (STDs), including gonorrhea, is often associated with substance abuse. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.¹

While lower than historic levels, Washington State is experiencing a serious resurgence in gonorrhea cases, from 1,949 cases in 1998 to 2,991 cases in 2001, representing a 53.5% increase. From 2000 to 2001, the rate of gonorrhea cases in Washington State rose from 41.6 per 100,000 people to 50.1 per 100,000, representing a 20.4% increase. Much of this increase is associated with cases among men having sex with men in King County, where the rate has more than doubled since 1997, and may be as much as six times greater than for heterosexuals.²

Gonorrhea infections are a major cause of pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pain. Gonorrhea rates also serve as an indicator for other STDs.³

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC, 2000.

² STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health, *Sexually Transmitted Disease Morbidity, 2001-- Washington State*. Olympia, WA, 2002.

³ *Ibid.*

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

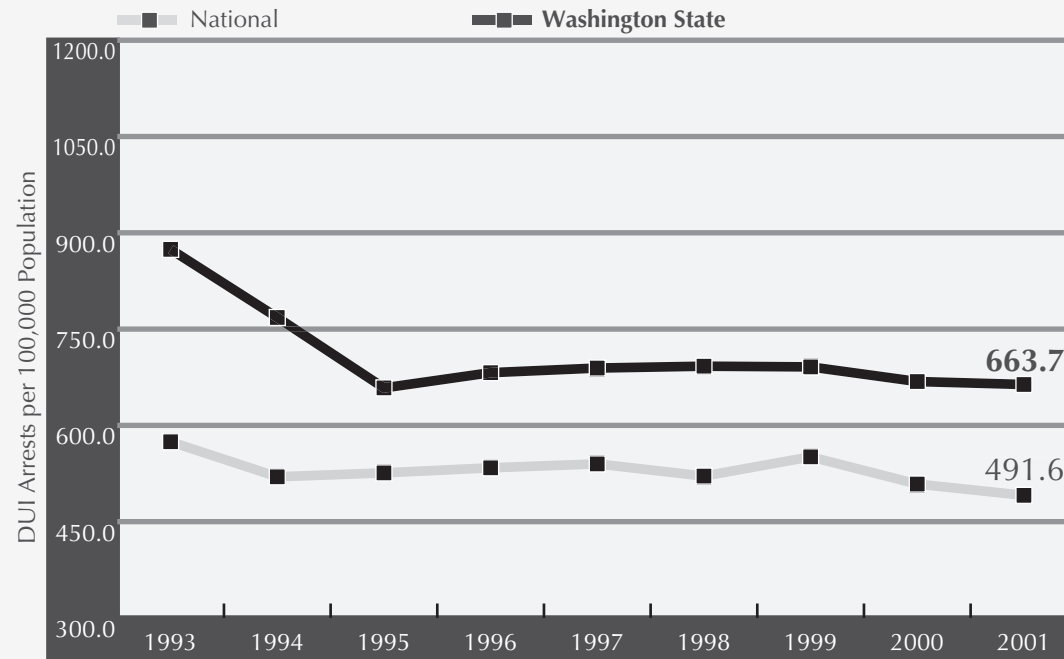
Crime

Violence

Family
Distress



Alcohol-Related Motor Vehicle Arrest Rates in Washington State Have Remained Steady for the Past Seven Years.

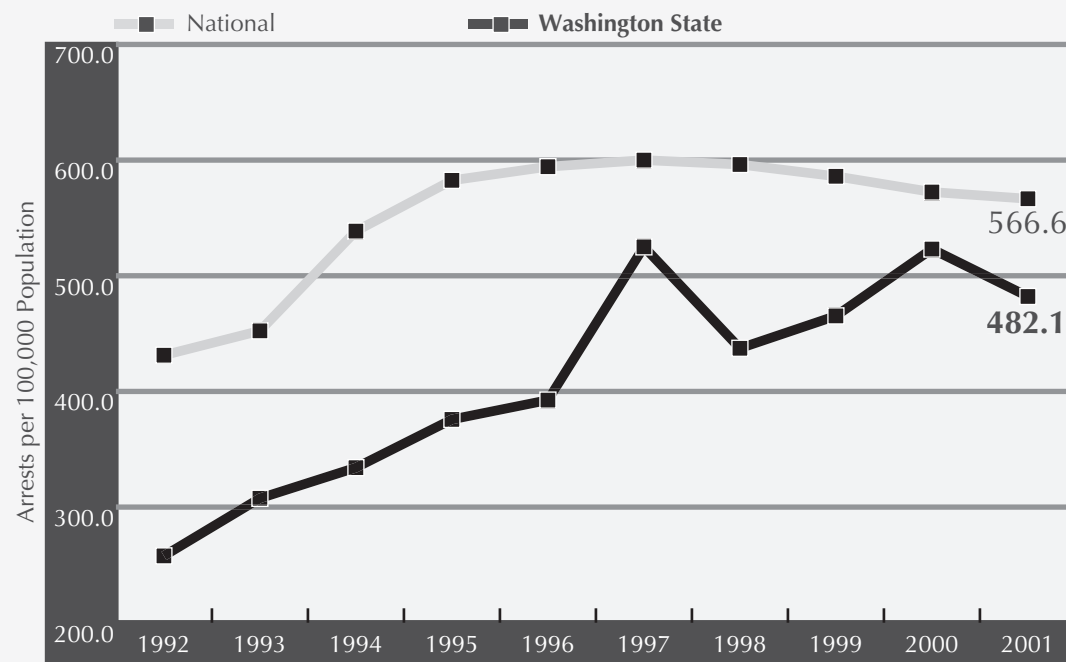


Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States Annual Reports*. State data from Washington State Patrol Breathalyzer Database.

Data for alcohol-related motor vehicle arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of alcohol-related driving incidents. Washington State enacted new alcohol-related motor vehicle statutes in 1998 – including lowering the blood alcohol concentration for proof of intoxication from .10 to .08, and zero tolerance for drivers under age 21. While these statutes have not resulted in higher arrest rates, they have resulted in lower alcohol-related motor vehicle fatality rates.¹

¹ Salzberg, Philip, and Anne Yamada. *Drunk Driving Trends in Washington State: Evaluation of the 1998 DUI Laws*. Olympia, WA: Traffic Research and Data Center, Washington State Traffic Safety Commission, 2002.

Washington State Has a Lower Arrest Rate for Drug Abuse Violations than the Nation.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington* annual reports.

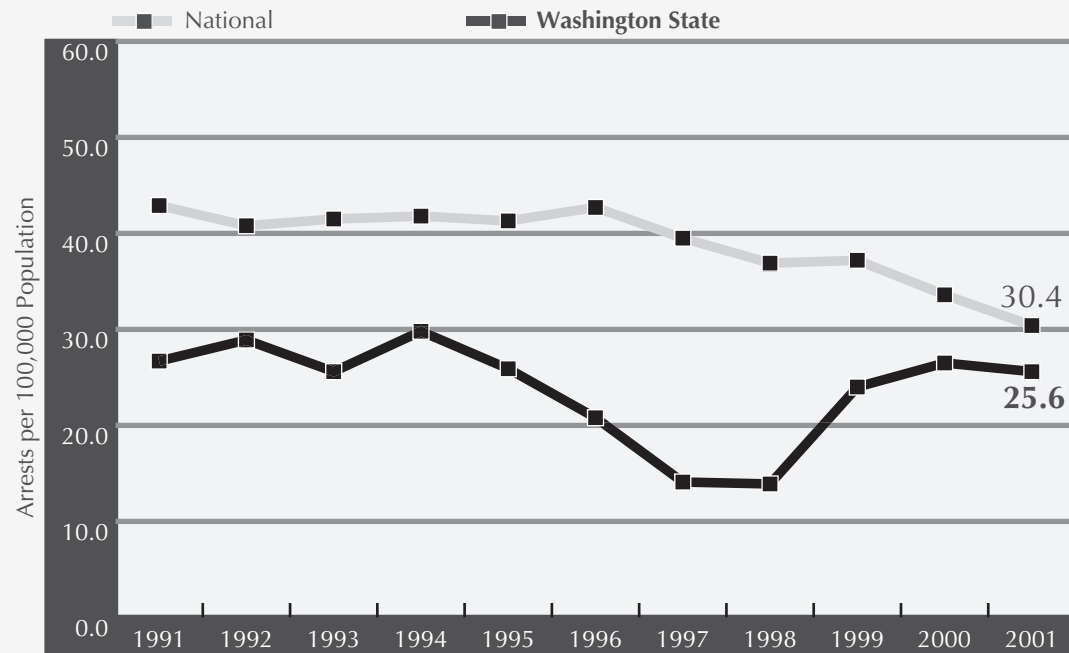
This graph indicates that although fewer drug-related arrests per capita occur in Washington State than the nation, the rate is increasing. Arrests made for drug abuse violations provide a direct measure of illegal activity related to substance abuse. A drug abuse violation is any transgression of state or local laws that results from the unlawful possession, sale, use, growing, or manufacture of narcotic drugs. Arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of drug-related criminal activity.

There were 28,043 arrests in Washington State for drug abuse violations in 2001. In 2000, 64.2% of the males and 73.9% of females arrested and booked in King County jails tested positive for illicit drugs. In Spokane, 57.9% of males and 41.7% of females tested positive.¹ Under sentencing reform legislation enacted in the 2002 Legislative Session, an individual arrested and filed upon by the prosecutor for a drug-related offense is now more likely to receive chemical dependency treatment as part of a diversion program or in lieu of incarceration after conviction.

¹ Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports* (Prerelease). Washington, DC: U.S. Department of Justice, 2001.



Arrest Rates in Washington State for Prostitution are Below the National Rate.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington* annual reports.

The Arrestee Drug Abuse Monitoring Program reports that 78.3% of those arrested for prostitution in Seattle in 1999 tested positive for illegal drugs, mostly for cocaine.¹

This graph indicates that arrest rates for prostitution in Washington State are significantly lower than that of the nation. It should be noted that arrest rates may be influenced by a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of criminal activity.

¹ Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 1999 Annual Report*, 60. Washington, DC: U.S. Department of Justice, 2000.

Washington State Has a Higher Property Crime Index than the Nation.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington* annual reports.

The Arrestee Drug Abuse Monitoring Program found that in 2000, 73.4% of males arrested for property offenses in King County, and 71.5% arrested for property offenses in Spokane County tested positive for illegal drugs.¹

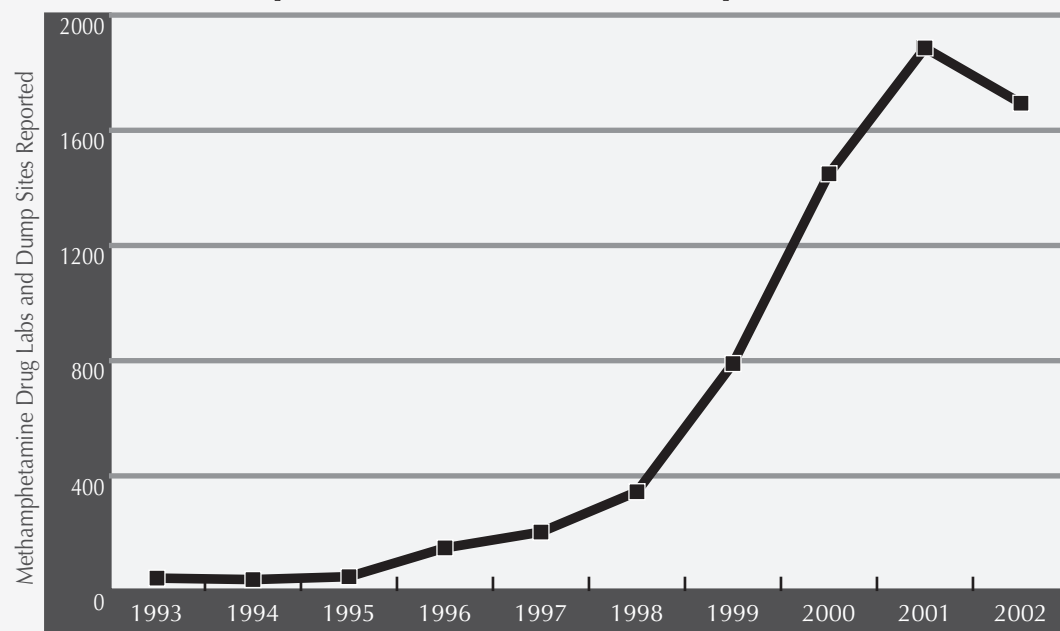
This graph indicates that the Washington State property crime index is higher than the nation's, but is in a downward trend. The property crime index includes burglary, larceny-theft, motor vehicle theft, and arson. Distinct from arrest data, this index counts one offense for each victim who reports a property crime to the police, regardless of the number of offenders involved.

¹ Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports* (Prerelease), 139-146. Washington, DC: U.S. Department of Justice, 2001.



For the First Time in a Decade, the Number of Reported Methamphetamine Laboratories in Washington State has Dropped.

Number of Reported Meth Labs and Dump Sites



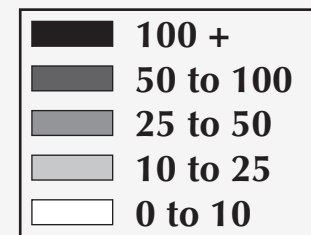
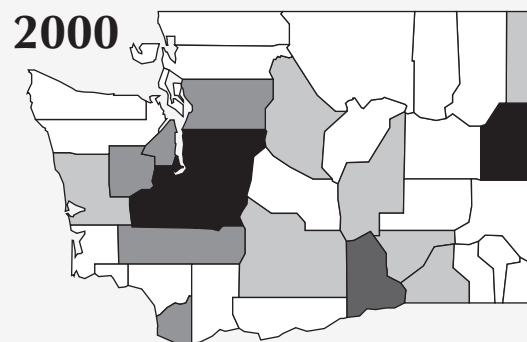
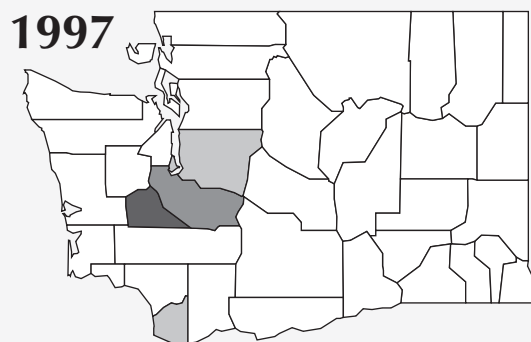
Source: Washington State Department of Ecology, 2003.

This graph indicates that after dramatic increases since 1994, the number of illegal methamphetamine (meth) laboratories and dumpsites reported to the Department of Ecology dropped by 10.2% in 2002. This downward swing confirmed by the fact that the number of labs reported in the second half of 2002 (719) was substantially lower than in the first half (975). On a monthly basis, the number of reports peaked in February 2001 (202). The largest number of reports in 2002 came from Pierce (438), King (241), Spokane (190), and Thurston (115) Counties. The most rapid growth in reports was in Grant County, from no reports in 1998 to 46 reports in 2002.

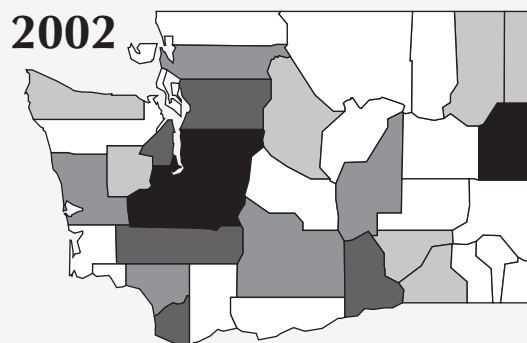
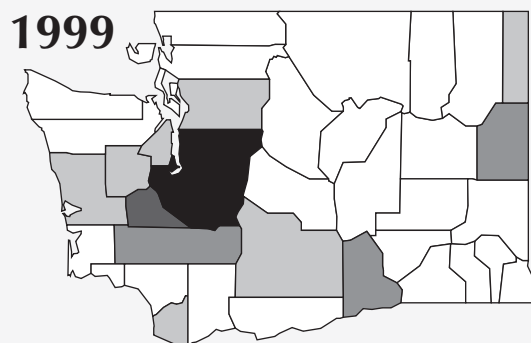
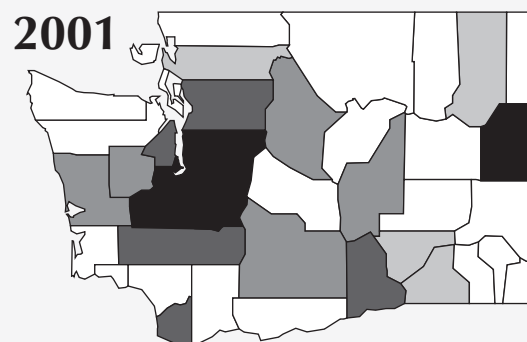
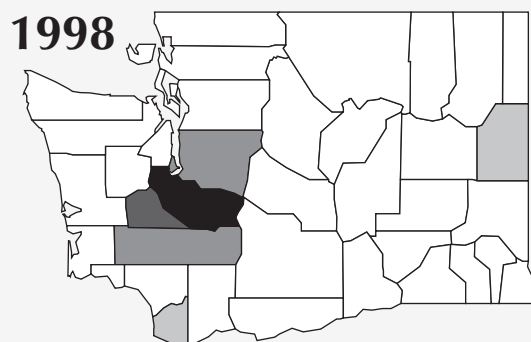
It is likely, but not yet substantiated, that the number of meth lab reports reflects the level of illicit use of the drug in a community. It is also possible, however, that drug dealers are now importing finished product from elsewhere, rather than manufacturing it. It is now estimated that only one third of the methamphetamine used in Washington State is produced here.¹ Anecdotal reports also suggest that meth users may be increasingly turning to heroin use.

¹ Banta-Green, Caleb. *Washington State Drug Use Epidemiology*. Seattle, WA: Alcohol & Drug Abuse Institute, University of Washington, 2003.

Distribution of Methamphetamine Drug Laboratories and Dump Sites Reported by County



Source: Washington State Department of Ecology



These maps indicate widespread increase in reports of methamphetamine drug labs and dump sites by county. In 1991, only two counties - Pierce and King - had as many as ten reports. There have been huge increases in reports since then: in Pierce, from 18 to 543; King, from ten to 231; Thurston from four to 139; Spokane, from zero to 137; and Benton from zero to 52. As can be seen from the maps, the epidemic is spreading rapidly to virtually all portions of the state.

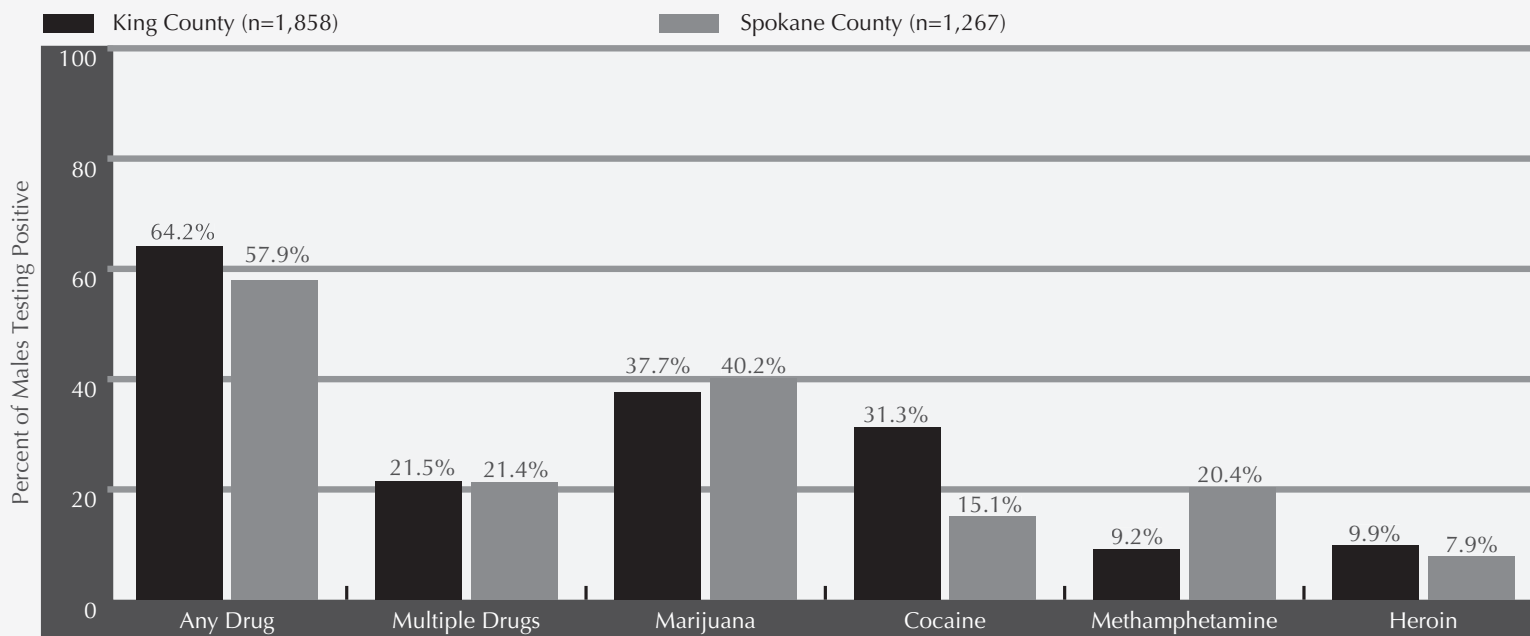


Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State

County	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Adams	-	-	-	-	-	1	-	1	-	3	4
Asotin	-	-	-	-	-	-	-	1	1	5	3
Benton	-	-	-	1	3	4	7	38	52	85	87
Chelan	-	1	-	1	1	-	-	2	14	34	15
Clallam	-	-	1	1	1	3	3	-	1	3	10
Clark	4	1	3	3	12	20	12	16	34	57	57
Columbia	-	-	-	-	-	-	-	1	3	2	1
Cowlitz	3	1	-	1	3	9	2	8	7	9	28
Douglas	-	-	-	-	-	-	1	1	6	5	7
Ferry	-	-	-	-	-	-	-	-	7	4	0
Franklin	-	-	-	-	-	-	1	8	10	15	11
Garfield	-	-	-	-	-	-	-	2	-	-	4
Grant	2	-	-	1	-	-	-	2	19	27	46
Grays Harbor	-	2	2	1	3	5	5	16	24	41	32
Island	-	-	-	1	-	1	2	5	1	5	5
Jefferson	-	-	-	-	-	1	1	2	7	6	4
King	2	7	7	10	23	17	48	107	231	271	241
Kitsap	2	1	-	-	3	-	1	21	45	54	60
Kittitas	-	1	-	1	-	-	1	3	-	5	3
Klickitat	1	-	-	1	1	1	3	-	6	4	2
Lewis	1	2	3	4	7	9	31	33	43	61	83
Lincoln	-	-	-	-	-	-	-	-	-	5	3
Mason	-	2	-	-	4	4	10	21	32	30	22
Okanogan	1	-	-	-	-	2	3	2	2	3	3
Pacific	-	-	-	1	-	4	1	6	2	3	4
Pend Oreille	-	1	-	-	-	2	6	10	12	5	12
Pierce	18	12	17	17	53	42	129	318	545	589	438
San Juan	-	-	-	-	-	-	-	-	-	1	1
Skagit	-	1	-	1	-	-	4	2	5	11	34
Skamania	-	-	-	-	-	-	-	2	1	2	3
Snohomish	-	2	-	-	7	6	5	13	37	69	83
Spokane	-	-	1	2	1	7	11	36	137	248	189
Stevens	-	-	-	-	1	1	-	5	4	15	10
Thurston	5	4	2	6	25	63	58	86	139	151	115
Wahkiakum	-	-	-	-	-	-	-	1	-	2	2
Walla Walla	-	-	-	-	-	-	2	8	12	16	15
Whatcom	-	1	-	-	-	-	-	-	-	5	9
Whitman	-	-	-	-	-	-	-	-	1	3	4
Yakima	-	2	-	1	5	1	2	12	14	36	43
TOTAL	39	41	36	54	153	203	349	789	1,454	1,890	1,693

Source: Washington State Department of Ecology.

Over Half of Males Arrested and Booked Into Jails in King and Spokane Counties in 2000 Tested Positive for Drugs.



Source: Office of Justice Programs, National Institute of Justice, U.S. Department of Justice, *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports*, 2001.

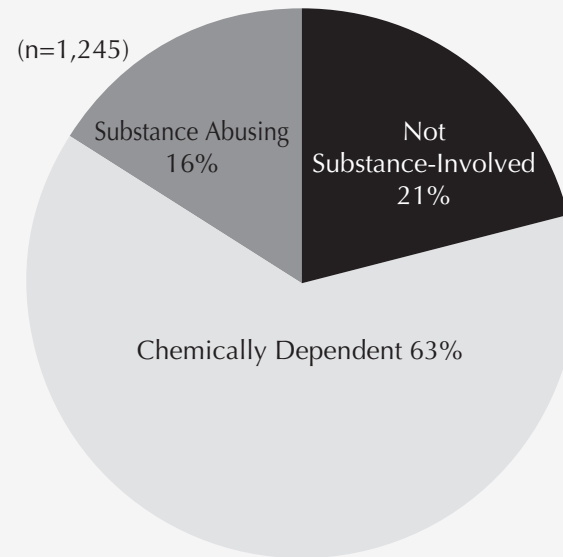
Through the Arrestee Drug Abuse Monitoring Program, individuals arrested and booked into jails in King and Spokane Counties are periodically tested via urine sampling for drug use at time of booking. Some 64.2% of male King County arrestees and 57.9% of male Spokane County arrestees tested positive for drugs in 2000. In addition, more than 70% of those booked for property offenses tested positive.

There are regional differences. The percentage of male King County arrestees testing positive for cocaine is twice the percentage of those in Spokane County. In contrast, the percentage of male arrestees in Spokane County testing positive for methamphetamine is double that of those in King County.¹

¹ Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports*. Washington, DC: U.S. Department of Justice, 2001.



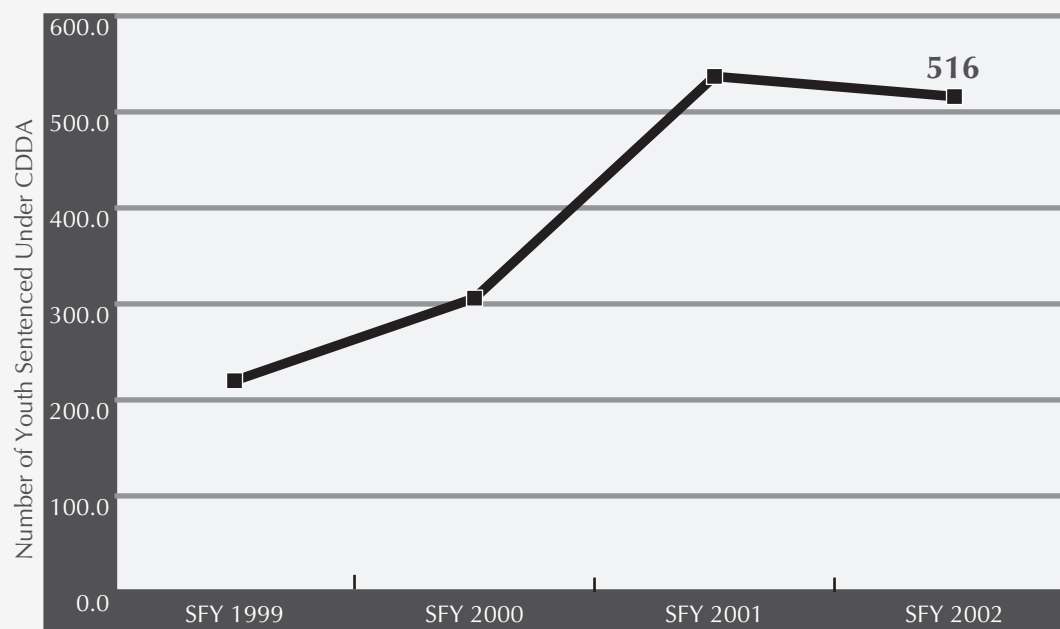
Approximately 79% of Youth Entering Juvenile Rehabilitation Administration Facilities Have Substance Abuse-Related Problems.



Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, February 2003.

Four out of five youths entering Juvenile Rehabilitation Administration (JRA) institutions have substance abuse-related problems. JRA offers a continuum of chemical dependency treatment services within its facilities. All services are certified by the Division of Alcohol and Substance Abuse (DASA). Approximately 56 youth are served each month, receiving inpatient, intensive outpatient, outpatient, and day treatment.

In State Fiscal Year 2002, 516 Youths Who Committed Offenses Received Treatment Under the Chemical Dependency Disposition Alternative.

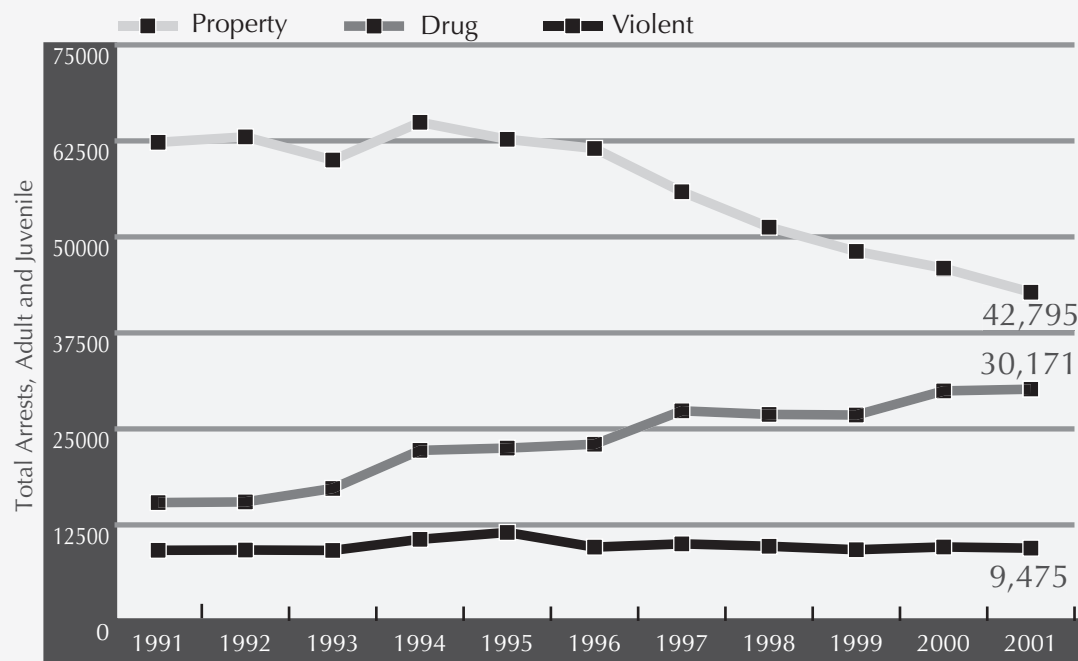


Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services.

In 1998, the Legislature created the Chemical Dependency Disposition Alternative (CDDA). Under CDDA, juvenile courts are provided the option of sentencing chemically abusing and dependent youth to treatment rather than confinement. CDDA represents a collaboration between the Juvenile Rehabilitation, the Division of Alcohol and Substance Abuse, the Medical Assistance Administration, local juvenile courts, University of Washington, and county alcohol/drug coordinators. Annual reports are provided to the Legislature on the effectiveness of CDDA programs. An outcome evaluation currently underway will examine CDDA's effectiveness in decreasing recidivism, reducing substance abuse, and improving school performance.



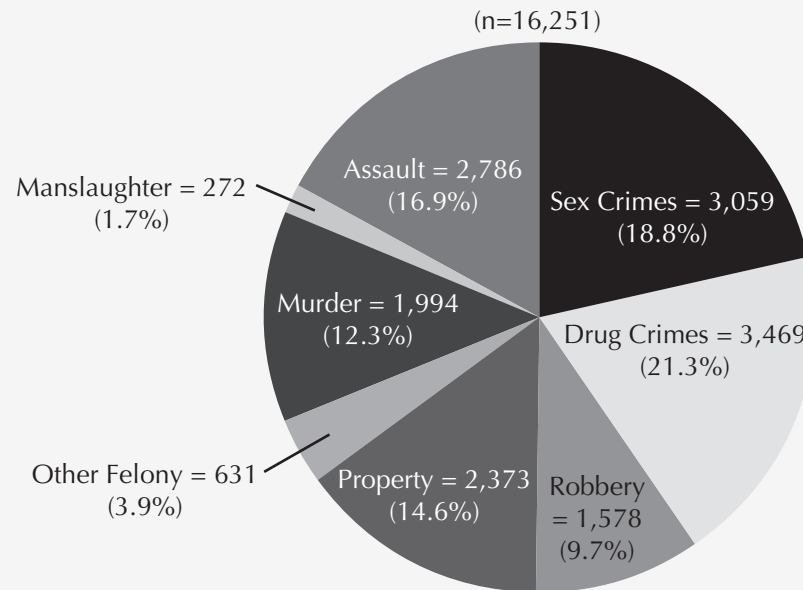
Arrests for Drug Offenses in Washington State Have Doubled Since 1991.



Source: Washington Association of Sheriffs and Police Chiefs, *Crime in Washington* annual reports; data adjusted by the Washington State Caseload Forecast Council.

Arrests in Washington State for drug offences have climbed from 15,494 in 1992 to 30,117 in 2001. During this same period, arrests for violent crime have remained stable, and arrests for property crime have dropped precipitously. Arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actually level of drug-related or other criminal activity.

More Inmates in Department of Corrections Custody are Convicted of Drug Offenses than Any Other Class of Crime.



Source: Planning and Research Section, Washington State Department of Corrections, *Client Characteristics, Population Movement, and Custody: Fiscal Year 2003, As of December 31, 2002.*

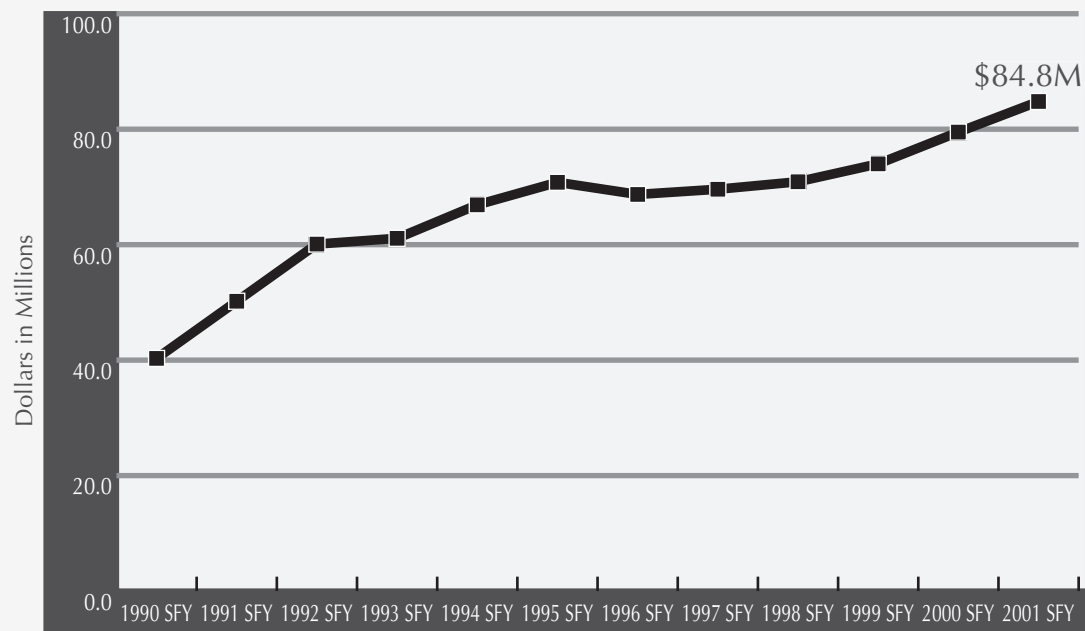
More than one in five inmates in the custody of the Department of Corrections – in prisons, pre-release facilities, and work release – were convicted of drug offenses, making drug crimes the largest category of offenses. Between 60-80% of inmates are estimated to be in need of chemical dependency treatment.¹ More than half of males arrested for violent offenses in King and Spokane Counties tested positive for illegal drugs.²

¹ Washington State Department of Corrections, January 2002.

² Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports*, 139-146. Washington, DC: U.S. Department of Justice, 2001.



Costs of Imprisoning Felony Drug Offenders in Washington State Have Doubled Since 1991.*



Source: Washington State Department of Corrections; Office of Program Research, Washington State House of Representatives.

Costs for imprisoning felony drug offenders in Washington State are growing faster than those for imprisoning other types of offenders. The number of imprisoned drug offenders has increased from 1,822 in SFY 1991 to 3,334 in SFY 2002. Some of this increase is due to longer sentences. New sentencing reform initiatives will divert a larger portion of drug offenders into chemical dependency treatment.

**Operating expenses only; excludes capital and supervision costs.*

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

Crime

Violence

Family
Distress



Washington State Has a Lower Homicide Rate than the Nation, and Has Now Reached the *Healthy People 2010* Objective.



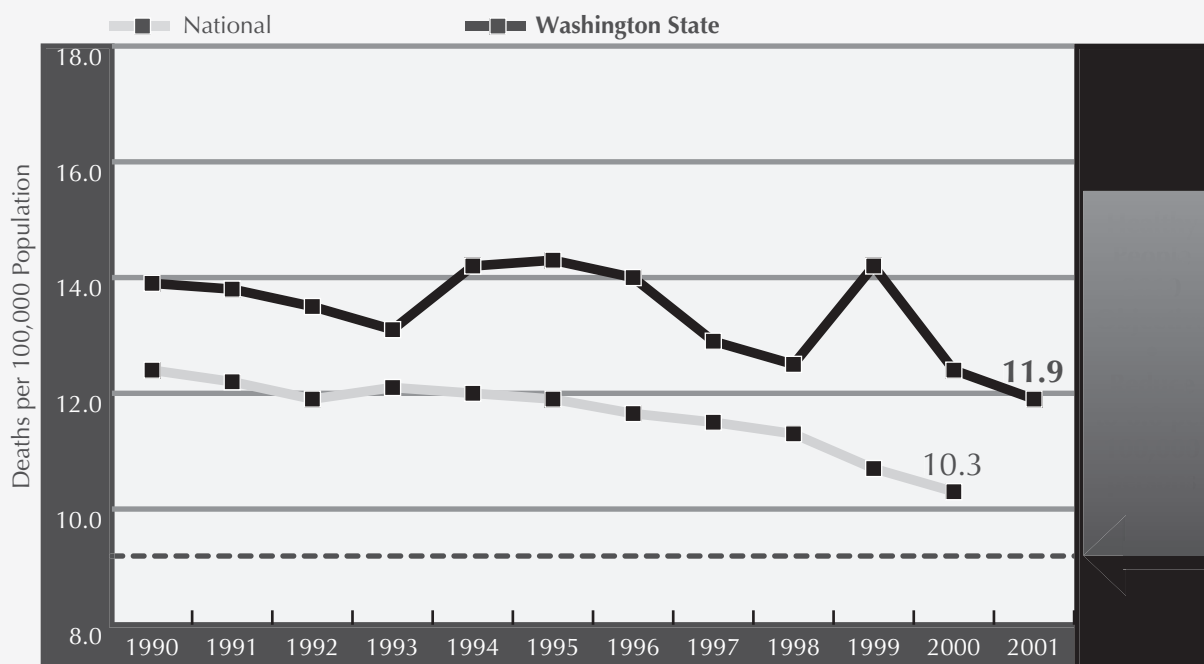
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States – 2001*. State data from the Center for Health Statistics, Washington State Department of Health.

The number of drug-related homicides in Washington State dropped substantially in 2001, to a total of six. Some 15 of the 142 non-felony homicide deaths (10.6%) in Washington State in 2001 occurred as a result of brawls while under the influence of alcohol.¹

This graph indicates that Washington State's homicide rate has been lower than the national rate for more than a decade, has dropped significantly since 1995, and has now reached the *Healthy People 2010* objective.

¹ Washington Association of Sheriffs & Police Chiefs, *Crime in Washington 2001 Annual Report*. Olympia, WA: 2002.

Washington State Has a Consistently Higher Suicide Rate than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from Center for Health Statistics, Washington State Department of Health.

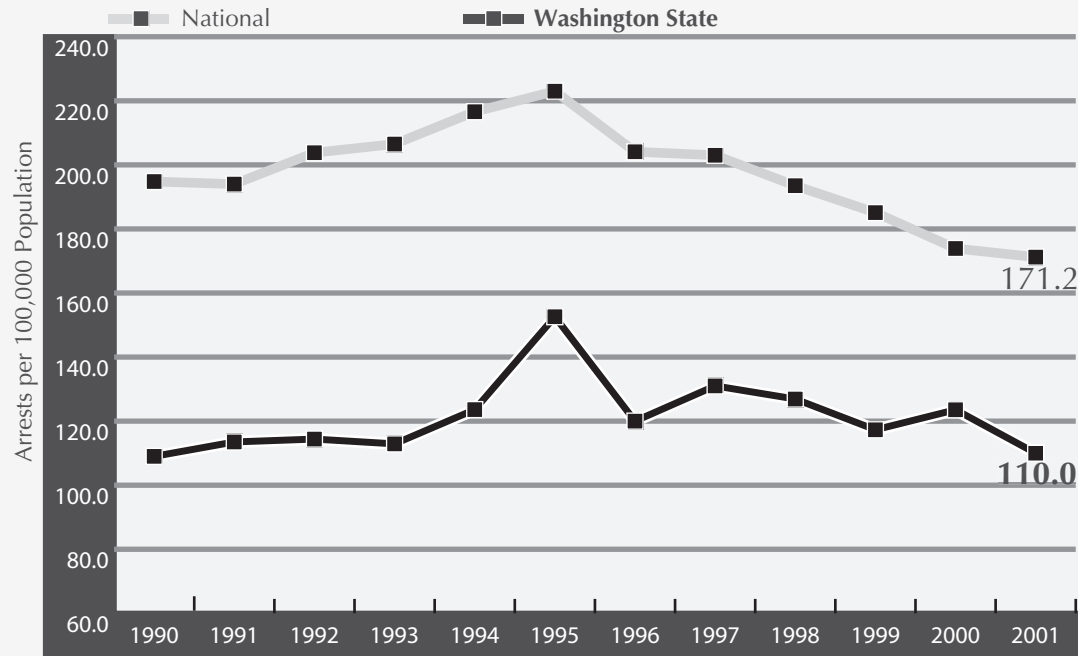
Alcohol and drug abuse are closely associated with the risk of suicide. A 1997 study found that use of alcohol almost doubles the risk of suicide in the home, while use of illegal drugs is associated with a seven-fold increase in risk.¹

Washington has a consistently higher suicide rate than the nation. Suicide remains the second leading cause of death among young people ages 15-24 in Washington State.

¹ Rivara, F. et al. "Alcohol and Illicit Drug Abuse and the Risk of Violent Death in the Home," *Journal of the American Medical Association* 278(7), 1997, 569-575.



The Arrest Rate for Aggravated Assault in Washington State Remains Well Below the National Rate.



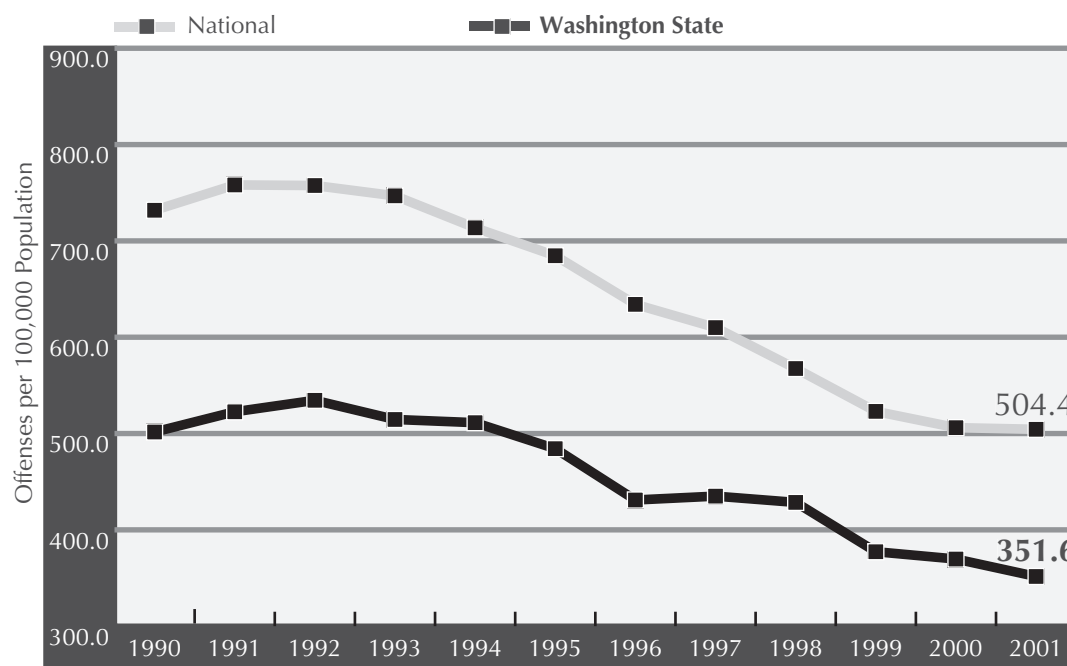
Source: National and state data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports.

The federal Uniform Crime Reporting Program defines an aggravated assault as the unlawful attack by one person on another for the purpose of inflicting or aggravating bodily injury. An assault of this type is usually accompanied by the use of a weapon, or by means likely to produce death or severe harm.

This graph indicates that Washington State has a consistently lower rate of aggravated assault arrests than the nation. Arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of criminal activity.

¹ Federal Bureau of Investigation, Uniform Crime Reporting Handbook, 16. Washington, DC: U.S. Department of Justice, 1984.

Washington State Consistently Has a Lower Rate of Violent Crime than the Nation.



Source: National and state data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports.

This graph indicates that Washington State has had a consistently lower incidence of violent crime than the nation for more than a decade. Violent crime rates are falling, both in the state and the nation. The Arrestee Drug Abuse Monitoring Program found that in 2001, 63.6% of males arrested for violent offenses in King County and 61.6% of males arrested for violent offenses in Spokane County tested positive for illegal drugs.¹

The most serious felony crimes against persons comprise the violent crime index. These offenses include murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. All violent crimes involve force or the threat of force. This index is based upon offenses that become known to police, regardless of whether or not an arrest occurs.

¹ Arrestee Drug Abuse Monitoring Program, Office of Justice Programs, National Institute of Justice. *Drug Use and Related Matters Among Adult Arrestees, 2001*. Washington, DC: U.S. Department of Justice, 2002.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

Crime

Violence

Family
Distress



The Divorce Rate in Washington State Has Dropped Significantly Over the Past Decade.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from Center for Health Statistics, Washington State Department of Health.

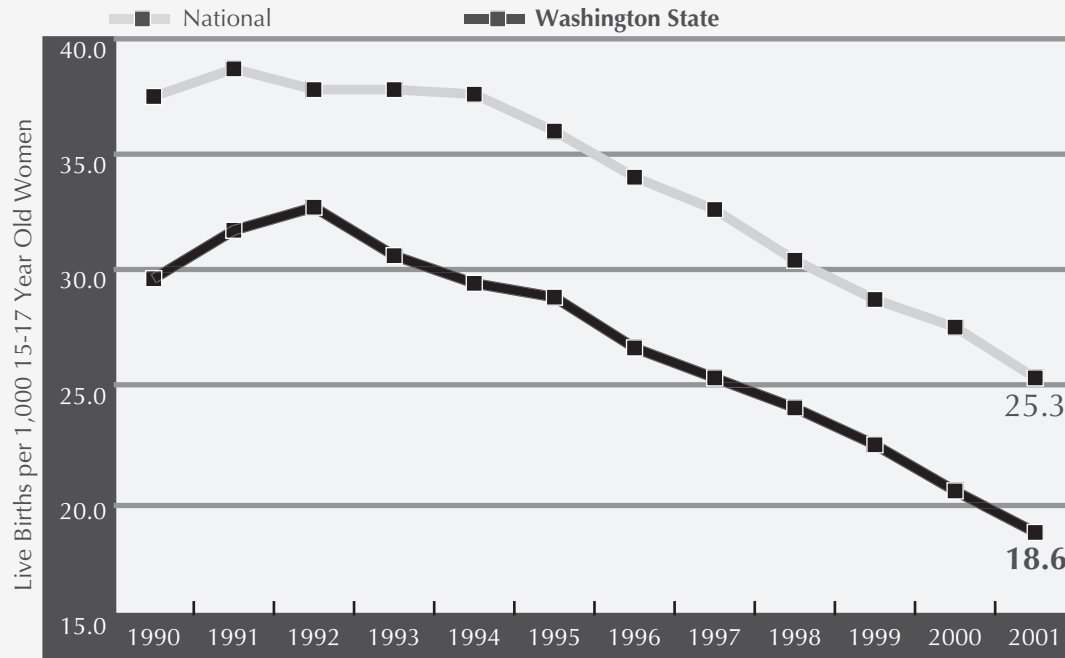
Studies indicate that children from homes broken by marital discord are at higher risk of drug use.¹

This graph indicates that couples in Washington State experience more divorces (including annulments) than couples nationwide. In 2001, at least 52.1% of the 26,451 divorces in Washington State involved families with children.²

¹ Kabel, J. et al. *Profile on Risk and Protection for Substance Abuse Planning in Washington State*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, 1997.

² Washington State Department of Health, Center for Health Statistics, 2002.

The Birth Rate Among Teens Ages 15-17 in Washington State is in Steep Decline.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from Center for Health Statistics, Washington State Department of Health.

Teen pregnancy is associated with alcohol and other drug use. In a survey of women in Washington State who were 18 years of age or younger at the time of their first pregnancy, almost one-quarter reported having used alcohol or another drug when they first became pregnant, and 36% reported that their partner used alcohol or drugs at that time.¹ Alcohol and drug use in pregnancy is closely associated with a range of health effects among children, including Fetal Alcohol Syndrome and mental retardation. In addition, maternal age is a significant risk factor for infant mortality.²

This graph indicates that the number of births per thousand among teens ages 15-17 is lower in Washington State than the nation, and continues to fall. It is now at its lowest level in two decades. In 2001, births to women under age 18 represented 2.9% of all births in Washington State.³

¹ Boyer, D. & Fine, D. "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives* 24(1), 1992, 4-12.

² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-3. Washington, DC: 2000.

³ Washington State Department of Health, Center for Health Statistics, 2002.

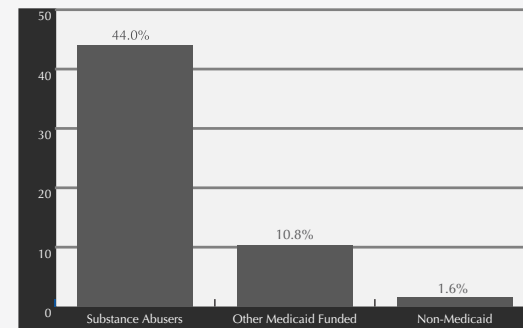


Infants Born to Low-Income Substance-Abusing Women Account for a Disproportionate Share of Child Protective Service (CPS) Referrals and Out-of-Home Placements.

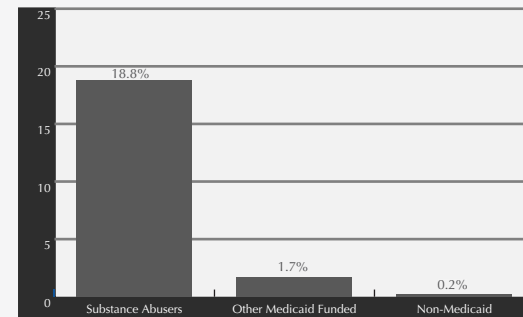
44% of Infants Born to Substance-Abusing Women Were Reported at “High Risk” of Imminent Harm.

18% of Infants Born to Substance-Abusing Women Were Placed Out of Home.

Percentage of Accepted CPS Referrals



Percentage of Out-of-Home Placements



Source: Cawthon, L., & Schrager. First Steps Database: *Substance Abuse, Treatment, and Birth Outcomes*. Office of Research and Data Analysis, Washington State Department of Social and Health Services, 1995.

Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect. The 1997 Child Maltreatment report from states to the National Child Abuse and Neglect Data System found approximately 984,000 victims of child maltreatment. Neglect accounted for 55.9% of these reports, followed by 24.6% for physical abuse, 12.5% for sexual abuse, and 6.1% for emotional abuse. It should be noted that 58.8% of the substantiated or indicated reports of maltreatment were from professional sources: legal, medical, social service, or educational professionals.¹

¹ U.S. Department of Social and Health Services. *Healthy People 2010* (Conference Edition), 15-44. Washington, DC: 2000.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment





Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) as the “single state” agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DASA or operate in coordination with DASA (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of the Superintendent of Public Instruction).

DASA does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DASA develops a plan for program development and prevention and treatment service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DASA in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on the available funding and submit a plan to DASA. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment



Prevention

The Division of Alcohol and Substance Abuse's (DASA) Prevention Program is aimed at preventing alcohol, tobacco, and other drug use and abuse, reducing their negative consequences and, minimizing future needs for chemical dependency treatment.

DASA's prevention program covers all segments of the population at potential risk for drug and alcohol use and abuse. However, the primary focus is on children who have not yet begun use or are still only experimenting. Research indicates that youth who initiate alcohol and/or other drug use before the age of 15 are twice as likely to experience alcohol or drug problems than those who wait until after the age of 19.¹ The U.S. Surgeon General's 1994 Report, "Preventing Tobacco Use Among Young People", found that if adolescents are kept tobacco-free, they are extremely unlikely to take up tobacco use later in life.²

DASA has two main prevention goals: 1) delay onset of use; and 2) reduce alcohol, tobacco, and other drug misuse. DASA has also adopted performance measures for the 2003-2005 Biennium: to increase the number of children in each of three grades – 6th, 8th, and 10th – who have not used alcohol, tobacco, or marijuana in the past 30 days.

The Division's Philosophy

DASA has adopted a "risk and protective factor" approach as the cornerstone of its efforts to prevent alcohol and other drug abuse. Risk factors are personal, family or community characteristics that increase the likelihood an individual will use alcohol or other drugs. Protective factors are similar characteristics that help insulate individuals from substance-abusing behaviors.

Seventeen risk factors have been identified for substance use/abuse, in four major categories:

1. Community:

- Availability of alcohol, tobacco, and other drugs
- Community laws and norms favorable to substance use
- Transitions and mobility
- Low neighborhood attachment and disorganization
- Extreme economic deprivation



2. Family:

- Family history of substance abuse
- Family management problems
- Family conflict
- Favorable parental attitudes and involvement with substance abuse

3. School:

- Early and persistent antisocial behavior
- Academic failure beginning in elementary school
- Lack of commitment to school

4. Individual/Peers:

- Rebelliousness
- Friends who use
- Favorable attitudes towards substance use
- Early initiation of substance use
- Constitutional factors³

Protective factors include individual protective characteristics, bonding to family, school, community and/or peers, and healthy beliefs and clear standards for behavior.

DASA contracts with the Department of Social and Health Services' Office of Research and Data Analysis to compile risk and protection profiles for each of the 39 counties. These profiles provide substantial support to counties in program planning resource allocation, and the development of outcome measures.

¹ Developmental Research Programs (1996). Communities that care planning kit. Seattle, WA: Developmental Research Programs.

² U.S. Surgeon General (1994). Preventing tobacco use among young people: a report of the Surgeon General. Washington, DC: U. S. Department of Health and Human Services.

³ Hawkins, J., Catalano, R. & Miller, J. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse preventions. Psychological Bulletin. 112 (1), pp. 64-105.



Principles of Effective Substance Abuse Prevention

The field of substance abuse prevention is still young, and local capacity for thorough program evaluation tends to be limited. To address this need, the federal Center for Substance Abuse Prevention has developed a list of 78 scientifically defensible principles that can help prevention providers design and implement programs that work. The Division of Alcohol and Substance Abuse encourages prevention providers to make use of these principles in working to curb tobacco, alcohol, and drug use among Washington youth.¹

Individual Domain

- Build social and personal skills.
- Design culturally sensitive interventions.
- Cite immediate consequences.
- Combine information dissemination and media campaigns with other interventions.
- Provide positive alternatives to help youth in high-risk environments develop personal and social skills in a natural and effective way.
- Recognize that relationships exist between substance use and a variety of other adolescent health problems.
- Incorporate problem identification and referral into prevention programming.
- Provide transportation to prevention programs.

Family Domain

- Target the entire family.
- Help develop bonds among parents in programs; provide meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
- Help minority families respond to cultural and racial issues.
- Develop parenting skills.
- Emphasize family bonding.
- Offer sessions where parents and youth learn and practice skills.
- Train parents to both listen and interact.
- Train parents to use positive and consistent discipline techniques.

¹ Detailed descriptions of each principle can be found at: www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf



Family Domain (continued)

- Promote new skills in family communication through interactive techniques.
- Employ strategies to overcome parental resistance to family-based programs.
- Improve parenting skills and child behavior with intensive support.
- Improve family functioning through family therapy when indicated.
- Explore alternative community sponsors and sites for schools.
- Videotape training and education.

Peer Domain

- Structure alternative activities and supervise alternative events.
- Incorporate social and personal skill-building opportunities.
- Design intensive alternative programs that include a variety of approaches and substantial time commitment.
- Communicate peer norms against use of alcohol and illicit drugs.
- Involve youth in the development of alternative programs.
- Involve youth in peer-led interventions, or interventions with peer-led components.
- Counter the effects of deviant norms and behaviors by creating an environment for youth with behavior problems to interact with other nonproblematic youth.

School Domain

- Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
- Correct misconceptions about the prevalence of use in conjunction with other education approaches.
- Involve youth in peer-led interventions or interventions with peer-led components.
- Give students opportunities to practice newly acquired skills through interactive approaches.
- Help youth retain skills through booster sessions.
- Involve parents in school-based approaches.
- Communicate a commitment to substance abuse prevention in school policies.



Community Domain

- Develop integrated, comprehensive prevention strategies rather than one-time community-based events.
- Control the environment around schools and other areas where youth gather.
- Provide structured time with adults through mentoring.
- Increase positive attitudes through community service.
- Achieve greater results with highly involved mentors.
- Emphasize the costs to employers of workers' substance use and abuse.
- Communicate a clear company policy on substance abuse.
- Include representatives from every organization that plays a role in fulfilling coalition objectives.
- Retain active coalition members by providing meaningful rewards.
- Define specific goals and assign specific responsibility for their achievement to subcommittees and task forces.
- Ensure planning and clear understanding for coalition effectiveness.
- Set outcome-based objectives.
- Support a large number of prevention activities.
- Organize at the neighborhood level.
- Assess progress from an outcome-based perspective and make adjustments to the plan of action to meet goals.
- Involve paid coalition staff as resource providers and facilitators rather than as direct community organizers.

Society/Environmental Domain

- Develop community awareness and media efforts.
- Use mass media appropriately.
- Provide structured time with adults through mentoring.
- Avoid the use of authority figures.
- Broadcast messages frequently over an extended period of time.
- Broadcast messages through multiple channels when the target audience is likely to be viewing or listening.
- Disseminate information about the hazards of a product or industry that promotes it.



Society/Environmental Domain (continued)

- Promote replacement of more conspicuous labels.
- Promote restrictions on tobacco use in public places and private workplaces.
- Promote clean indoor air laws.
- Combine beverage server training with law enforcement.
- Combine beverage servers' legal liability with laws against service to intoxicated patrons and against sales to minors.
- Increase the price of alcohol and tobacco through excise taxes.
- Increase minimum purchase age for alcohol to 21.
- Limit the location and density of retail alcohol outlets.
- Employ neighborhood anti-drug strategies.
- Enforce minimum purchase age laws using undercover buying operations.
- Use community groups to provide positive and negative feedback to merchants.
- Employ more frequent enforcement operations.
- Implement "use and lose" laws.
- Enact deterrence laws and policies for impaired driving.
- Enforce impaired-driving laws.
- Combine sobriety checkpoints with positive passive breath sensors.
- Revoke licenses for impaired driving.
- Immobilize or impound vehicles of those convicted of impaired driving.
- Target underage drivers.



Children's Transition Initiative (CTI)

Based on statewide risk and protective factor data, and prevalence data collected through the 1998 Washington State Adolescent Health Behavior Survey, DASA has begun piloting a new Children's Transition Initiative (CTI) in seven counties. Survey data show a sharp rise in youth alcohol, tobacco, and marijuana use between grade school and middle school, and again between middle school and high school. National research findings demonstrate the benefits of providing prevention services to youth over time. These findings provide the basis for CTI, the goal of which is to prevent children, ages 9 to 16, from using alcohol, tobacco, marijuana, and other drugs.

Through CTI, existing county programs will identify discrete youth populations at high risk for drug initiation. Prevention programming will be specifically tailored for each group, depending on individual risk factors, protective factors, and assets.

The following primary outcomes have been identified for CTI:

- Enrolled youth will demonstrate a significantly higher rate of abstinence from alcohol, tobacco, marijuana, and other drugs than non-enrolled youth with similar risk factors, protective factors, and assets.
- There will be a 50% increase in the awareness of risk and protective factors associated with substance abuse by parents or caregivers of CTI-participating children.
- 80% of children enrolled in CTI will be retained in the initiative for a minimum of 12 months.

Secondary outcomes will be negotiated between DASA and counties, and may include targeted risk and protective factors in the school, family, peer, or community domains. From July 1999 through January 2002, 265 children and families have been enrolled in CTI services in the following counties: Benton, Franklin, Columbia, Grant, Island, Lincoln, Spokane, Skamania, Whatcom, Pierce, Lewis, and Clark.

County Prioritized Risk Factors



The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.

TARGETED RISK FACTORS	COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Mason	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston	Wahkiakum	Walla Walla	Whatcom	Whitman	Yakima	
Availability of Alcohol + Other Drugs																																							
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Favorable Attitudes Toward Substance Use																																							
Early Initiation of Substance Use																																							
Constitutional Factors																																							

Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.



County Prioritized Protective Factors

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Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.



Tribal Prioritized Risk Factors

The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.

TARGETED RISK FACTORS ▼	TRIBE	Hoh	Jamestown S'Klallam	Lower Elwha Klallam	Makah	Muckleshoot	Nisqually	Port Gamble S'Klallam	Puyallup	Quileute	Quinault	Samish	Sauk Suiattle	Shoalwater Bay	Skokomish	Snoqualmie	Squaxin Island	Stillaguamish	Suquamish	Swinomish	Tulalip	Upper Skagit	Yakama
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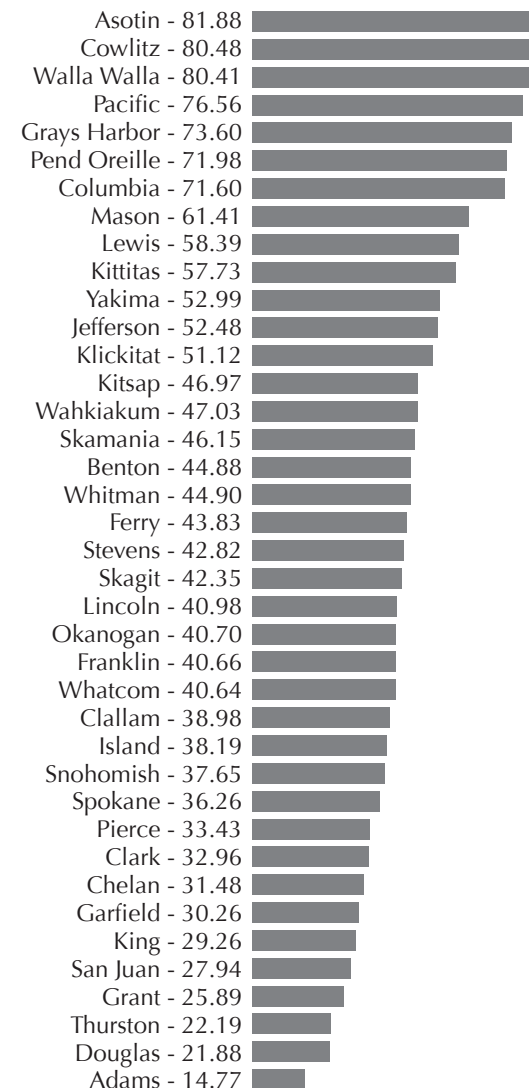
Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Risk Factor: Family Management Problems – Victims of Child Abuse and Neglect

Poor family management practices include lack of clear expectations for behavior, failure of parents to know where their children are and who they are with, and excessively severe or inconsistent consequences for negative behaviors. These practices have been shown to increase the risk of drug abuse, delinquency, teen pregnancy, school dropout, and violence.

Successful management intervention strategies focus on developing parenting skills, and emphasize family bonding. These programs often have sessions in which parents and youth learn and practice skills both separately and together.

**Rates of Accepted Referrals for Child Abuse and Neglect
(5-Year Average -- Per 1,000 Children)**



Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

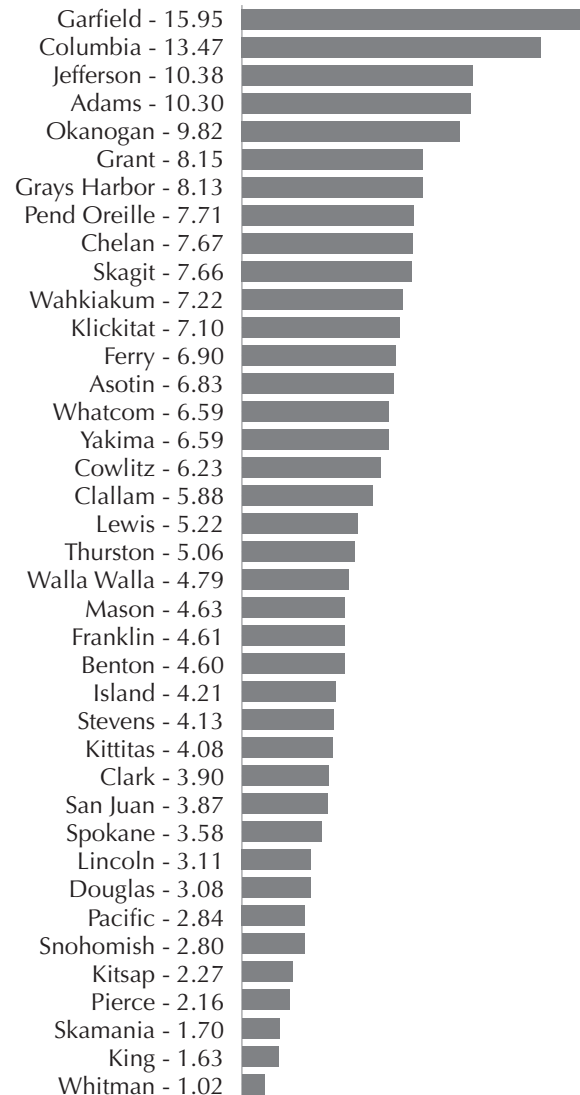


Risk Factor: Early Initiation of Problem Behavior – Alcohol- or Drug-Related Arrests (Ages 10-14)*

The earlier young people begin using drugs, engaging in violent activity, committing crimes, dropping out of school, and becoming sexually active, the greater the likelihood they will have problems with these behaviors later on. Due to the compelling nature of the evidence, many planners target 'age-of-first-use' for prevention efforts. Communities seek to reduce risk factors that lead to early experimentation and provide children with skills necessary to resist substance use.

**It should be noted that arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of drug-related criminal activity.*

**Rates of Alcohol- or Drug-Related Arrests, Adolescents Ages 10-14
(5-Year Average -- Per 1,000 Adolescents Ages 10-14)**

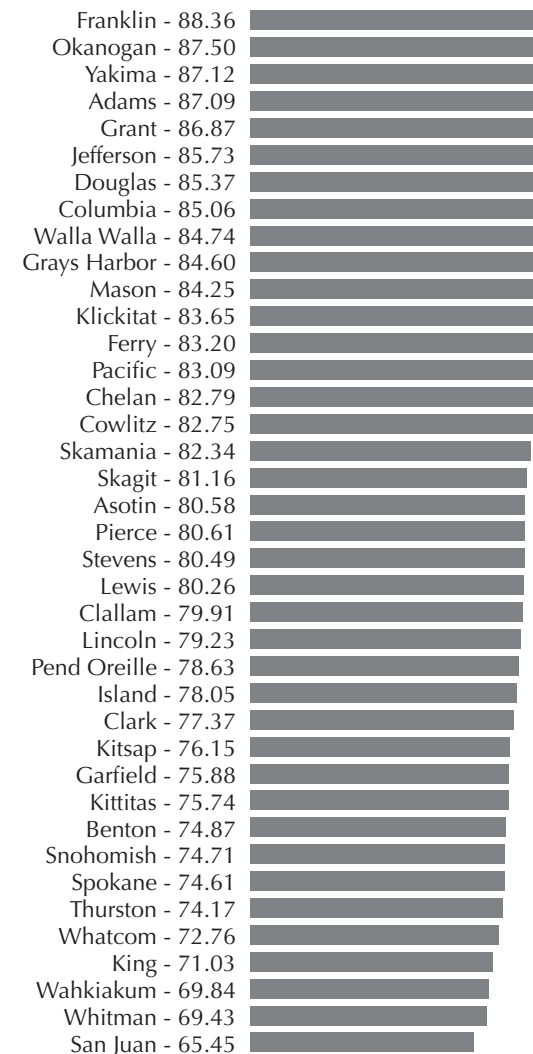


Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Risk Factor: Low School Achievement – Poor Academic Performance

Beginning in fourth and fifth grades, academic failure increases the risk of substance abuse as children continue on in school. Children experience academic failure for many reasons. Many researchers believe that risk factors increase when students are unable to experience some satisfaction from their academic efforts. Prevention programs focus on academic skill-building through after-school programs, and improving children's early learning opportunities. Communities and families must partner with schools so that all children can become achievers.

**Rates of Fourth Graders Who Failed One or More Content Areas in the Washington Assessment of Student Learning (WASL)
(5-Year Average -- Per 1,000 Fourth Graders)**



Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.



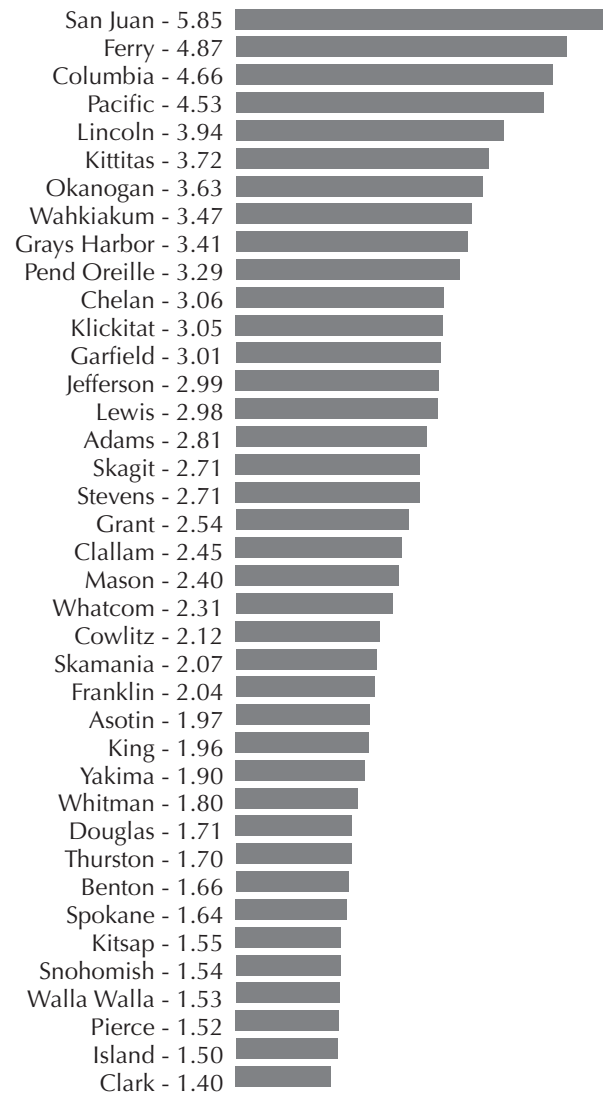
Among adults, research has shown that alcohol use is associated with availability, including the number of outlets at which it can be purchased. No data on illicit drug availability is readily available.

In many communities across the state, coalitions of law enforcement, Liquor Control Board agents, prevention professionals, schools, and others have worked to increase enforcement of underage purchase laws. Recent data suggest that as youth perceive increased difficulty in purchasing alcohol, alcohol use declines.

Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Risk Factor: Availability of Drugs – Alcohol Retail Licenses

*Rates of Active Alcohol Retail Licenses
(5-Year Average -- Per 1,000 Persons)*

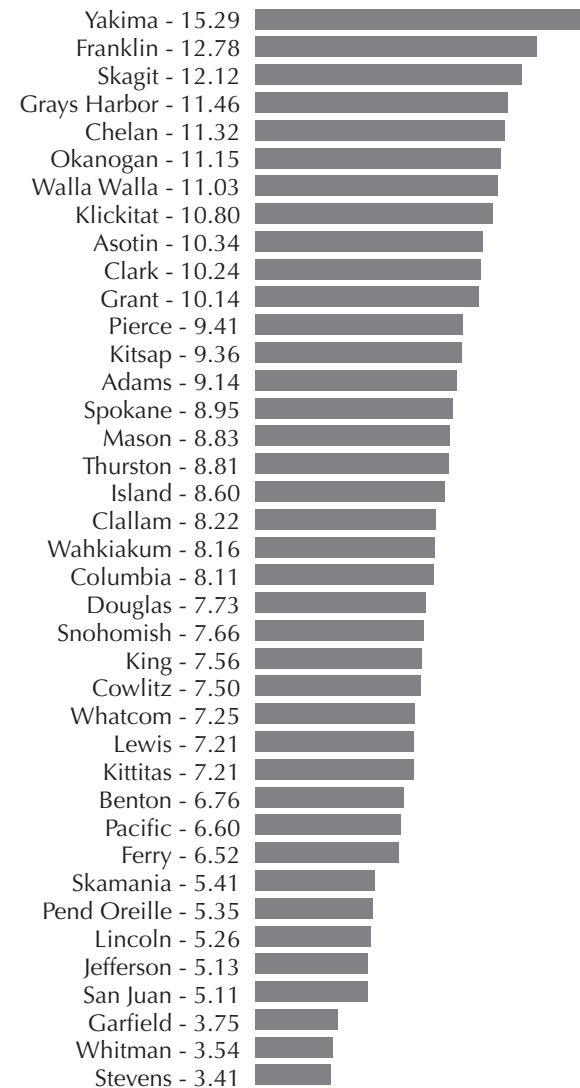


Risk Factor: Low Commitment to School – High School Dropouts

Children with low commitment to school, low educational aspirations, and poor motivation are at risk for problem behaviors. It is likely that youth who perform poorly academically fail to develop bonds to school, and will have lower expectations of success.

Efforts to reduce this risk factor encompass community, family, and school, as well as children and youth themselves. Prevention efforts in a community would seek to raise the value placed on education. Parents can be taught skills for encouraging and supporting their child's education. Mentoring programs can also assist youth in setting future-oriented goals.

Rates of Number of Students Grades 9-12 Who Dropped Out of School in a Single Year (5-Year Average -- Per 100 Students)



Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.



Statewide Prevention Services

The Division of Alcohol and Substance Abuse (DASA) provides prevention services primarily by way of interagency agreements and partnerships with other state agencies. The following programs are either partially or fully funded by DASA:

Washington State School-Based Prevention and Intervention Services Program

The Office of Superintendent of Public Instruction (OSPI) administers a school-based program targeting students at risk for developing alcohol, tobacco, and other drug related problems. During the 2001-2003 Biennium, the Prevention and Intervention Services Program was implemented by 13 local grantees across Washington State. Geographically, these grantees covered all regions of the state. Some 292 intervention specialists delivered services to 22,947 K-12 students in 765 schools.

Survey of Adolescent Health Behaviors

OSPI administers an adolescent health behaviors survey in Washington schools every two years. The survey represents a collaborative effort among OSPI, DASA, Department of Health, and the Department of Community, Trade and Economic Development. Alcohol, tobacco, and other drug use prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state. The 2002 Survey of Adolescent Health Behaviors was the seventh statewide survey. The most recent survey was conducted in the fall of 2002. More than 137,000 students in 752 schools in 6th, 8th, 10th and 12th grades took the survey, and nearly 25,000 students were included in the state sample.

Reducing Underage Drinking Initiative (RUaD)

In 1998, the Washington State Coalition to Reducing Underage Drinking (RUaD) was established to oversee the implementation of program components delineated in Washington State's proposals to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Enforcing the Underage Drinking Laws (EUDL) program. Since 1999, over \$2.2 million dollars has been awarded to Washington State. EUDL funding to Washington State supports programs including; compliance checks of retail outlets; the training of merchants to recognize fake IDs; police emphasis patrols; media campaigns; education to minors about the consequences of underage drinking; and school-based alcohol use prevention programs utilizing best practices. Communities currently receiving EUDL funds in Washington State include: City of Kent, Washington State and Western Washington Universities, and Kitsap, Mason, Chelan, Douglas, Benton, Franklin, and Grays Harbor Counties.



Reducing Access to Tobacco Products (Synar Regulation)

The federal Substance Abuse Prevention and Treatment (SAPT) block grant requires that states focus on reducing youth access to tobacco products through retail outlets. The so-called Synar Amendment requires states to reach and maintain a maximum 20% non-compliance rate as measured through compliance checks. The Division of Alcohol and Substance Abuse (DASA) coordinates with two other state agencies – the Department of Health (DOH) and Liquor Control Board (LCB) – to implement youth tobacco compliance checks that meet Synar rules established by the federal Center for Substance Abuse Prevention. DOH develops a randomized list of tobacco retailers in the state. Local health departments and districts organize and implement the youth access compliance checks. DOH uses the results of the local health jurisdictions' compliance checks to calculate an overall state compliance rate. LCB provides technical assistance and enforcement follow-up for local youth access checks.

In 1995, when the first Synar checks were conducted, the State's non-compliance rate was 25.1%. Since 1999, non-compliance rates have ranged from 11.2-13.9%, well within that required under Synar.

Washington State Substance Abuse College Coalition

The University of Washington facilitates the Washington State Substance Abuse College Coalition. The Coalition was established to facilitate the development, implementation and continuation of substance abuse prevention programming at all college and university campuses in Washington State. Coalition members administer campus-based prevention services targeting students and university communities. The Coalition meets six times during the academic year on different campuses throughout the state, and sponsors the annual Pacific Northwest Conference on Collegiate Wellness. The Coalition recently authored a report to college presidents with information about the Coalition, its recent efforts, and plans for a statewide initiative to address alcohol and other drug abuse on college campuses.

Washington State Alcohol/Drug Clearinghouse

The Washington State Alcohol/Drug Clearinghouse provides accurate and timely resource materials and information on alcohol, tobacco, and other drug abuse prevention. Materials and information are accessible for Washington State residents, including non-English speaking individuals and persons with disabilities. The Clearinghouse maintains a statewide toll-free phone number for individuals requesting resources, including a system for receiving requests by telephone from the hearing-impaired community. There is also a 24-hour response protocol, and a video library. The Clearinghouse serves as Washington State's Regional Alcohol and Drug Awareness Resource (RADAR) Network State Center, and provides services in accordance with RADAR guidelines developed by the National Clearinghouse for Alcohol and Drug Information. The Clearinghouse also distributes an electronic newsletter to communicate information about prevention practices and activities/campaigns to individuals and organizations in Washington State. The Clearinghouse fulfills some 8,000 requests for resources each biennium.



Communications and Media Program

The purpose of the Communications and Media program is to educate youth, parents, policymakers and other members of the public about the connection between substance abuse and health and social problems, effective ways to prevent and reduce alcohol and drug abuse; and ways to access prevention and treatment resources in Washington State.

The program consists of the following elements:

- **Partnership for a Drug Free Washington (PDFW):** An ongoing media campaign to disseminate effective prevention messages via multi-media advertising, and provide drug abuse education materials for educators, parents, and youth.
- **FOCUS Newsletter:** A quarterly publication providing news, resources, and information for advancing the field of substance abuse prevention and treatment in Washington State.
- **Resources for Promoting Community-Based Awareness Events:** DASA partners with state and community agencies to sponsor activities and provide resources for Drug Free Washington Month, National Alcoholism and Drug Addiction Recovery Month, and other events.
- **Media Relations:** DASA provides information about new research, resources, and key events to the news media, and responds promptly to all media inquiries.

Washington State Mentoring Initiative

The Washington State Mentoring Partnership serves as a prevention network sponsored by DASA to expand the field of mentoring throughout Washington State, increase societal awareness regarding the benefits of mentoring, and expand private sector participation. The Washington State Mentoring Partnership is comprised of mentoring program administrators, service providers, and advocates. DASA provides technical assistance to prevention planners and providers interested in developing local mentoring programs. In 2002, both the Governor's and Lieutenant Governor's Offices participated in National Mentoring Month activities.



Children's Transition Initiative (CTI)

DASA established the Children's Transition Initiative (CTI) to encourage prevention providers to address the risk and protective factors in children transitioning from grade school to middle school and middle school to high school. CTI requires enrollment of children and their families for a minimum of 12 months, and the utilization of research-based prevention strategies. CTI counties include: Benton, Columbia, Ferry, Franklin, Grant, Island, Lincoln, Skamania, Spokane, and Whatcom.

Preliminary results are promising. Of the 64 youth who participated in CTI for the first year: 36% showed improvement in family management issues; 31% reported more appropriate attitudes regarding drug use; 31% reported fewer relationships with friends who used alcohol or other drugs; and 67% resisted the trend among their age group to increase alcohol and drug experimentation.

Washington State Exemplary Substance Abuse Prevention Awards

The Washington State Exemplary Substance Abuse Prevention Awards Program recognizes outstanding substance abuse prevention programs, individuals working in the prevention field, and media organizations that support prevention efforts. A review committee evaluates the applications received and approves those meeting the selection criteria. Members of the committee also nominate and select additional individuals for their special contributions to the field. Awardees are honored at the Washington State Prevention Summit in Yakima. The state awards process is designed to coordinate with the existing national awards process, with the goal of identifying Washington State Exemplary Programs that could be encouraged to apply at the national level.

Community Prevention Training System (CPTS)

The Community Prevention Training System (CPTS) provides financial support to counties and tribes for capacity building so that they will be able to deliver prevention services which represent science-based "best and promising practices". CPTS funds are not intended to support prevention programs. Rather, they are intended to ensure that communities are able to take advantage of, or make available, trainings that enhance the level of expertise and knowledge of the latest prevention research. Efforts are made to ensure that all prevention contractors have access to the fund. Some 30 counties and seven tribes applied for and received CPTS support during the past Biennium, with funds matched by the counties and tribes themselves.



Washington State Incentive Grant

In July 1998, Governor Gary Locke received a four-year, \$8.9 million State Incentive Grant (SIG) awarded by the federal Center for Substance Abuse Prevention. The grant was used to fund initiatives to reduce youth alcohol, tobacco, marijuana, and other drug use; reduce factors that put youth in grades 4-10 at risk for substance abuse; and enhance factors that provide protection for youth against these risks. The Division of Alcohol and Substance Abuse (DASA) was designated as the lead agency managing the grant, with the Department of Social and Health Services' Research and Data Analysis Division as the primary evaluator.

Washington State Substance Abuse Prevention System

In March 2001, Governor Locke issued a document titled *Washington State Incentive Grant Substance Abuse Prevention System*. Prepared by the 32-member Governor's Substance Abuse Advisory Committee, the document included signed commitments by the directors of state agencies, councils, commissions, and boards involved in substance abuse prevention "to work together to address Washington State's overarching objectives and institute strategies for a State Substance Abuse Prevention System."

Participating state entities include the Governor's Executive Policy Office, Office of the Lieutenant Governor, Department of Social and Health Services, Office of Superintendent of Public Instruction, Office of Community, Trade & Economic Development, Department of Health, Liquor Control Board, Governor's Juvenile Justice Advisory Committee, Family Policy Council, Washington State Traffic Safety Commission, Governor's Council on Substance Abuse, and Citizens Advisory Council on Alcoholism and Drug Addiction.



State Incentive Grant Objectives

In March 1999, the Governor's Substance Abuse Prevention Advisory Committee, and Governor Locke issued, a Washington State Substance Abuse Prevention Plan. The goal of the Plan is to "streamline state-level prevention systems to coordinate resources and reduce duplication of effort." Below is a table listing the six objectives of the Plan and steps being taken to address them.

Approved March 1999

Objective 1 To identify and adopt a set of common outcome measures building on the emerging consensus of a "science-based" risk and protective factor approach to prevention.

Objective 2 To develop and coordinate administration of common community needs and resource assessment tools.

Objective 3 To define selection criteria to identify the science-based prevention programs which can best address the needs identified from common assessment and measures.

Objective 4 To develop uniform reporting mechanisms which can capture outcomes of individual community prevention programs.

Objective 5 To develop guidelines for leveraging and redirecting money and resources based on the confidence of the scientifically established outcome measures, uniform community assessments, and reliable reporting.

Objective 6 To create a system for continuous professional development for all prevention providers, both volunteer and paid.

Approved March 2001

Participating state agencies reached agreement to work on 18 overarching state outcome objectives and corresponding benchmark objectives. The Governor's Council on Substance Abuse is the lead designated to prepare "report" cards on the progress of reaching the benchmarks every two years.

Participating state agencies reached agreement to expand the existing Community Outcome Risk Evaluation Geographic Information System currently being managed by the Department of Social and Health Services, Research and Data Analysis Division to collect the data necessary to track the overarching state outcome objectives.

The Western Center for the Application of Prevention Technology (WestCAPT) is the lead for ensuring that community prevention providers have access to current information on science-based prevention programs and programs with promising approaches. At the present time, detailed information is available on CD ROM and via the Internet at <http://www.unr.edu/westcapt/>.

The SIG Community Projects are continuing to field-test a prevention outcome evaluation and monitoring system called *Everest*. The goal is to have this system available to interested prevention providers from participating state agencies and from the community at large. *Everest* is a Web-enabled system that:

- (1) Generates pre/post tests designed to measure outcomes of participants in prevention programs;
- (2) Provides a confidential screen for input of the test results;
- (3) Matches the pre-and post information; and
- (4) Immediately generates a series of outcome reports.

Participating state agencies have achieved tremendous accomplishments through collaboration. In addition to working together on the various aspects of the objectives as described, the state agencies achieved the following:

- (1) Consolidated administration of school-based adolescent health behavior survey to be administrated every two years in the fall of the second year of the state biennial cycle; and
- (2) Administrated collaborative community needs assessment that allowed for one assessment to be jointly conducted on the local level and submitted for use by multiple funding state agencies.

The Western Center for the Application of Prevention Technology (WestCAPT) is the lead for ensuring that community prevention providers have access to training that will prepare them on the most current findings related to prevention and implementation of science-based prevention programs and programs with promising approaches. WestCAPT is developing a state calendar for training opportunities.



In the development of the State Incentive Grant State Substance Abuse Prevention System, 18 objectives were set, and responsibility assigned to those state agencies expected to take the lead in moving the state toward meeting those objectives.

State Incentive Grant Overarching Outcomes and Benchmark Objectives

#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
SAFETY													
1.	Reduce alcohol-related motor vehicle crash deaths.	1997 4.74 per 100,000	4.0 per 100,000		X			•			•		•
2.	Reduce illicit drug-related deaths.	1998 5.93 per 100,000	3 per 100,000		X			•					
3.	Reduce the number of young people in Grades 9 through 12 who reported that they rode, during the previous 30 days, with a driver who had been drinking alcohol.	1999 29%	25%	X		•		•			•		•
4.	Increase the percentage of students reporting that they feel safe in school.	2000 Grade 6 - 86% Grade 8 - 77.4% Grade 10 - 77.5% Grade 12 - 85%	Grade 6 - 90% Grade 8 - 90% Grade 10 - 90% Grade 12 - 90%	X						•		•	
5.	Reduce the percentage of youth at risk because they do not perceive communities as having strong laws and norms against substance use.	2000 Grade 6 - 37.5% Grade 8 - 33.3% Grade 10 - 44.1% Grade 12 - 42.3%	Grade 6 - 25% Grade 8 - 25% Grade 10 - 30% Grade 12 - 30%	X		•	•	•			•	•	
SENSE OF BELONGING													
6.	Improve bonding and strong attachment to family. (Data for this objective are available for limited communities in the state, not a representative sample.)	1995 Grade 6 - 83% Grade 8 - 71% Grade 10 - 66% Grade 12 - 70%	Grade 6 - 90% Grade 8 - 80% Grade 10 - 75% Grade 12 - 75%	X		•		•		•			
SOCIAL INTEGRATION INTO COMMUNITY													
7.	Increase opportunities for pro-social involvement of youth in their community.	1998 Grade 6 - 42.4% Grade 8 - 56.5% Grade 10 - 48.9% Grade 12 - 47.1%	Grade 6 - 75% Grade 8 - 75% Grade 10 - 75% Grade 12 - 75%	X		•	•	•		•		•	
8.	Increase rewards for pro-social involvement in the community.	1998 Grade 6 - 67.4% Grade 8 - 52.6% Grade 10 - 55.7% Grade 12 - 51.5%	Grade 6 - 75% Grade 8 - 75% Grade 10 - 75% Grade 12 - 75%	X		•		•		•		•	



#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
LEARNING AND SKILL BUILDING													
9.	Improve academic achievement for all students.	2000 Grade 4 Grade 7 Grade 10	In development	X		•						•	
10.	Reduce the percentage of students at risk due to low commitment to school.	1998 Grade 6 - 35.2% Grade 8 - 39.4% Grade 10 - 42.5% Grade 12 - 47.3%	Grade 6 - 20% Grade 8 - 25% Grade 10 - 25% Grade 12 - 25%	X		•		•				•	
11.	Reduce the number of truant students defined as students who have five unexcused absences in a month or ten unexcused absences in a year.	In development	In development	X						•		•	
12.	Increase high school completion rate.	In development	In development	X		•						•	
HEALTH													
13.	Reduce the proportion of youth reporting use during the past 30 days of:	2000 Grade 6 - 6.6% Grade 8 - 22.3% Grade 10 - 37.6% Grade 12 - 46.8%	Grade 6 - 4% Grade 8 - 15% Grade 10 - 25% Grade 12 - 35%		X	•	•	•			•	•	
	• Alcoholic beverages				X	•	•	•					
	• Marijuana	2000 Grade 6 - 1.5% Grade 8 - 12% Grade 10 - 21.9% Grade 12 - 24.4%	Grade 6 - 0% Grade 8 - 5% Grade 10 - 10% Grade 12 - 10%		X	•		•					
	• Any illicit drug (includes marijuana)	2000 Grade 6 - 3% Grade 8 - 15.6% Grade 10 - 24.2% Grade 12 - 26.3%	Grade 6 - 0% Grade 8 - 5% Grade 10 - 10% Grade 12 - 10%		X	•		•					
	• Cigarettes	2000 Grade 6 - 4% Grade 8 - 12.5% Grade 10 - 19.8% Grade 12 - 27.6%	Grade 6 - 2% Grade 8 - 6% Grade 10 - 10% Grade 12 - 12%		X	•	•	•			•		
	• Smokeless tobacco	2000 Grade 6 - .8% Grade 8 - 2.1% Grade 10 - 4.6% Grade 12 - 8.8%	Grade 6 - 0% Grade 8 - 1% Grade 10 - 2% Grade 12 - 4%	X		•	•	•			•		

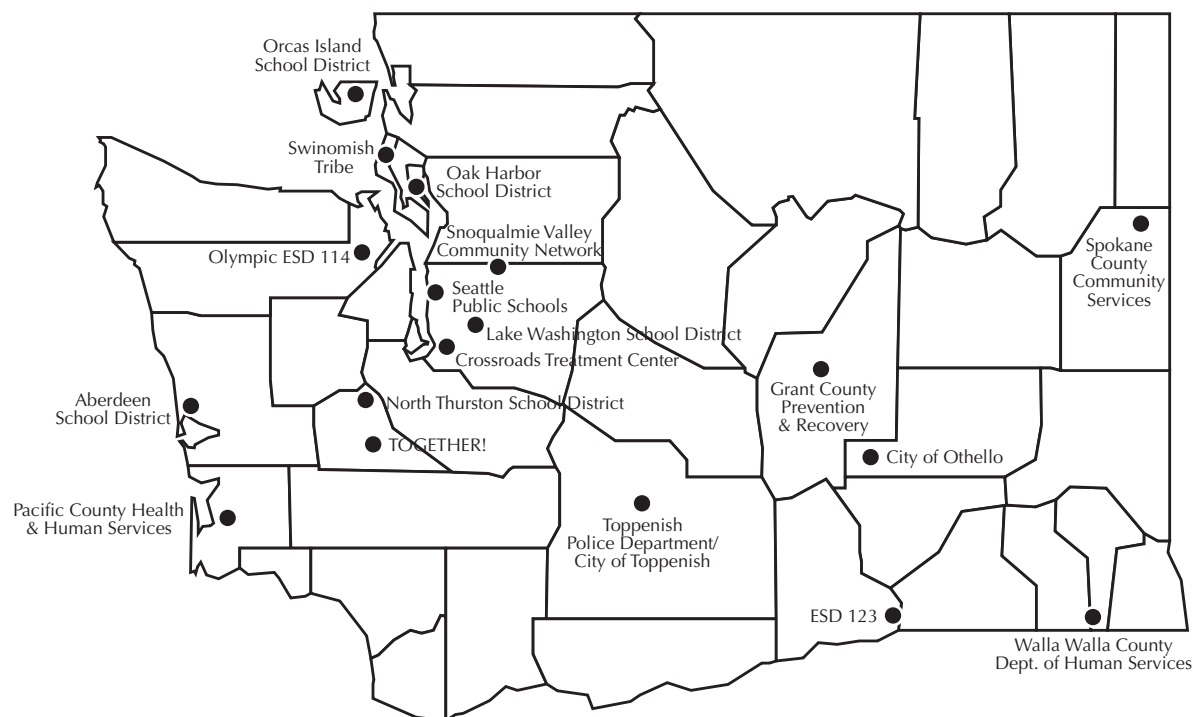


#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
HEALTH (CONT.)													
14.	Reduce back to 1990 levels, the proportion of youth reporting binge drinking during the past two weeks	2000 Grade 6 - 4.7% Grade 8 - 14.9% Grade 10 - 23.2% Grade 12 - 31.8%	Grade 6 - 4% Grade 8 - 12% Grade 10 - 18% Grade 12 - 20%		X	•		•			•		
15.	Reduce the proportion of (college age), 18- to 24-year-olds reporting some-time in their lives: • Binge drinking	1998 37%	25%		X								
	• Use of marijuana	18%	15%				•	•					
	• Use of any illicit drug	21%	17%										
	• Use of cigarettes	37%	25%										
16.	Increase abstinence by pregnant women: • Any use in the past month • Binge drinking • Illicit drugs • Cigarette smoking	In development	In development	X	X	•	•	•					
17.	Increase the percentage of youth who perceive the harmfulness of: • Smoking one or more packs a day	2000 Grade 6 - 87.5% Grade 8 - 90.8% Grade 10 - 93.3% Grade 12 - 94.5%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 100% Grade 12 - 100%	X		•	•	•				•	
	• Regular binge drinking	2000 Grade 6 - 69.4% Grade 8 - 71.8% Grade 10 - 76.8% Grade 12 - 73.7%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 100% Grade 12 - 100%	X		•		•				•	
	• Regular marijuana use	2000 Grade 6 - 83.3% Grade 8 - 84.6% Grade 10 - 81.3% Grade 12 - 79%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 95% Grade 12 - 95%	X		•		•				•	
18.	Increase the average age of first use of all substances to age 16: • Alcohol	1998 Age 14	Age 16	X		•		•					
	• Tobacco	Age 13	Age 16	X		•	•	•					
	• Marijuana	Age 14	Age 16	X		•		•					



State Incentive Grant Community Projects

For three years, 18 State Incentive Grant (SIG) communities from the state received funding to participate in a field-test of state- and community-level objectives included in the State Substance Abuse Prevention System Plan. These communities, in 15 counties, were able to demonstrate that they could establish successful partnership and coalitions to develop comprehensive community prevention action plans. Each community conducted a community needs assessment by collecting and reviewing data on alcohol, tobacco, and other drug use, and on risk and protective factors specific to their community. They used this data to target populations to receive prevention services, establish community-specific outcomes, and select and successfully implement evidence-based prevention services and activities. The SIG communities tested a web-based system to conduct their own outcome evaluations and used the results to reassess and revise community plans.

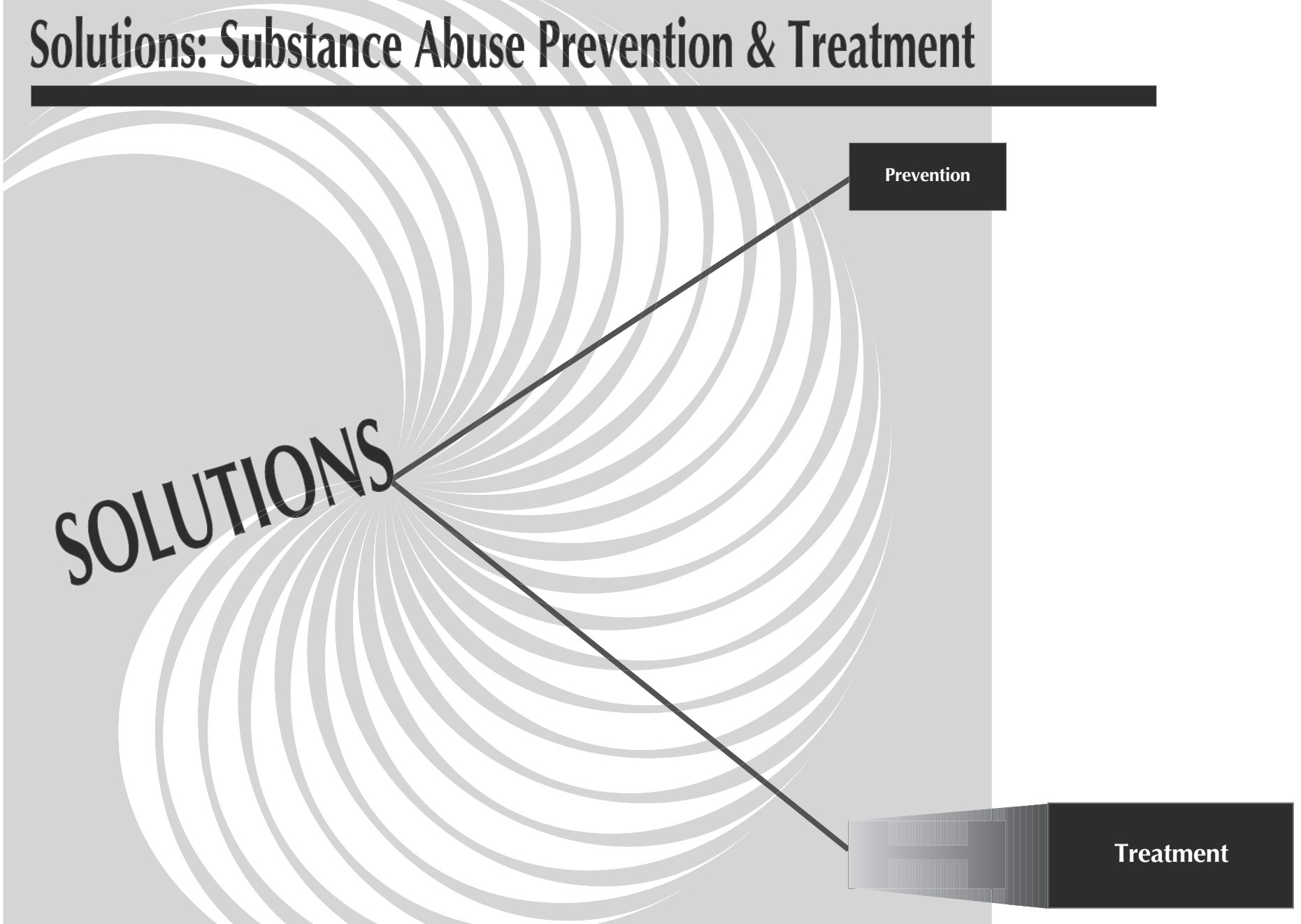


Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment





Introduction

Individuals are eligible for DASA-funded services if they are low-income or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating alcoholics and drug addicts.

Contracted treatment services include:

- Diagnostic evaluation
- Alcohol/Drug detoxification
- Outpatient treatment
- Opiate substitution (methadone) treatment
- Intensive inpatient treatment
- Recovery house
- Long-term residential care
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction
- Youth residential treatment
- Youth outpatient treatment
- Residential treatment for pregnant and parenting women (with child care)
- Outpatient treatment for pregnant and parenting women (with child care)
- Treatment for co-occurring disorders
- Tribal treatment programs
- Monolingual programs for non-English speakers
- Treatment program for the deaf/hard of hearing
- Urine screening



Specialized contracted support services for eligible individuals include:

- Child care
- Translation services (including interpreters for persons who are deaf or hard of hearing)
- Transportation assistance
- Case management
- Youth outreach
- Cooperative housing (Oxford House) and other transitional housing support

State and federal funding requirements give priority for treatment and intervention services to the following:

- Pregnant and postpartum women and families with children
- Families receiving Temporary Assistance for Needy Families (TANF)
- Child Protective Services referrals
- Youth
- Injection drug users (IDUs)
- People with HIV/AIDS



DASA Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

DASA's program of substance abuse services is based on knowledge gained from medical research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals.¹ As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services may be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into private or public treatment agencies. DASA's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequences of treatments. It is also important that specialized treatment services be available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DASA recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation.

A key aspect of DASA's philosophy is recognizing the generational loop of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of addicts in appropriate prevention activities, and providing early intervention services when needed.

¹See, for example: Wickizer, T., and Longhi, D. (1997). Economic benefits and costs associated with substance abuse treatment provided to indigent clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Olympia, WA: Washington State Department of Social and Health Service, Division of Alcohol and Substance Abuse. See also: Schrager, L. Joyce, J., and Cawthon, L., (1995). Substance abuse, treatment, and birth outcomes for pregnant and postpartum women in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Planning, Research & Development and Office of Research & Data Analysis.



Current Need for Treatment

Defining Current Need for Treatment

Based on a 1999 study conducted by the Department of Social and Health Services, Research and Data Analysis¹ and subsequently updated with current population projections, 418,567 adults (age 18 and older) living in households in Washington State were estimated to be in need of substance abuse treatment in 2001. This represents 9.9% of the population of adults living in households. (The definition of need is provided on the following page.) Treatment need for adolescents (ages 12-17) living in households is estimated at 8.7%.

The largest number of adults in need of treatment experienced an alcohol-related disorder. Among adults, 6.8% (275,906) experienced an alcohol use disorder in the past 18 months, while 1.6% (67,915) experienced a drug use disorder during the same period.

Use rates among adults living in households for individual substances were as follows:

	Lifetime Use	Past 12-Month Use	Past 30-Day Use
Alcohol	92.3%	71.6%*	55.6%
Any Illicit Drug	40.2%	9.8%	4.9%
Marijuana	38.6%	9.0%	4.7%
Stimulants**	16.3%	1.9%	0.8%
Cocaine	12.5%	1.6%	0.5%

*past 18-month use measure utilized for alcohol only

**Includes amphetamine, methamphetamine, and other stimulants.

¹ Holzer, C., Kabel, J., and Nordlund, D. (1999). Profile of substance use and need for treatment services in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis.



Current Need for Treatment Among Population Subgroups in Washington State

Current estimated need for treatment varies across population subgroups:

- Compared with the overall treatment need rate of 9.9% of adults living in households, some subgroups have lower estimated rates of treatment need. These include: those ages 45-64 (4.9%) and 65+ (2.0%); females (6.3%); Blacks (7.5%), Asian-Pacific Islanders (2.0%), and Hispanics (7.5%); those who are married (6.0%); and non-high school graduates (9.3%).
- Other subgroups have higher estimated need for treatment. These include: those ages 18-24 (24.7%) and 25-44 (12.4%); males (13.5%); Native Americans (American Indians or Alaskan Natives) (17.4%); and those never married (22.0%).

Significantly, need for substance abuse treatment is not highly correlated with income. Compared with need for treatment among all adult household residents (9.9%), 11.1% of adults in households with incomes at or below 200% of the federal poverty line had a current need for substance abuse treatment in 2001.

Those defined as currently in need of treatment met one of the following four conditions:

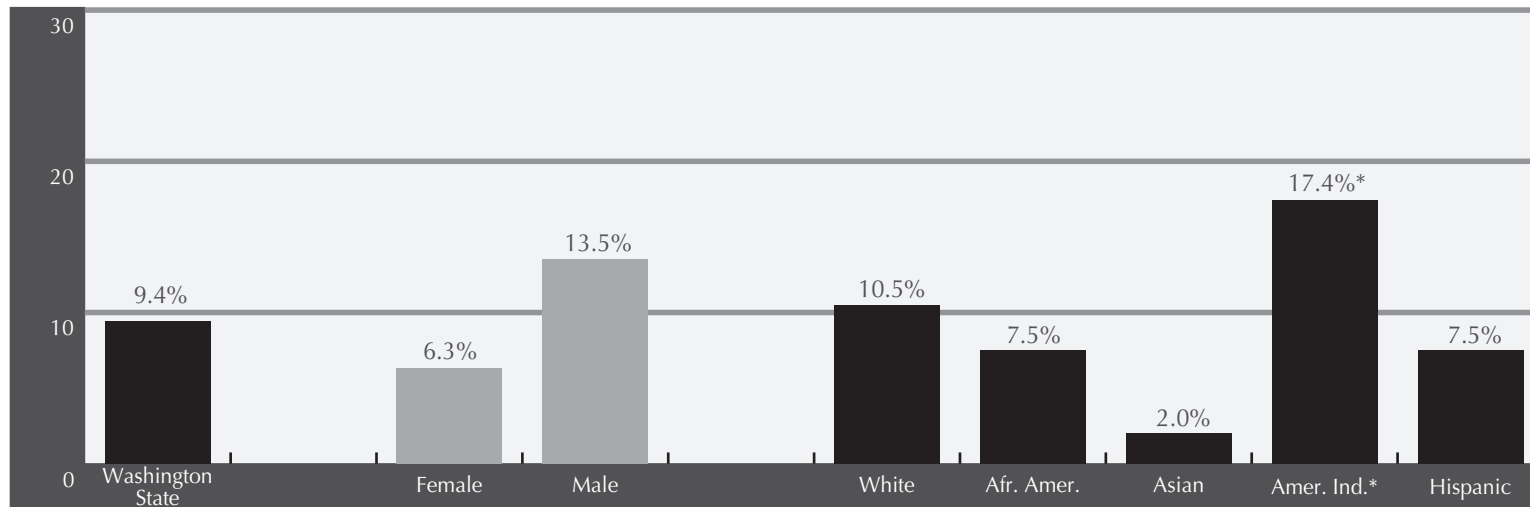
1. Individuals who had a substance use disorder in the past 18 months.
2. Individuals who did not meet the first condition but who reported that they have “had a problem or felt addicted to alcohol or drugs” AND reported drinking or using “regularly” during the past 18 months. “Regular” use means drinking three or more drinks per drinking day at least one or two times a week, OR using marijuana 50 times or more, OR using any other illicit drug ten times or more.
3. Individuals who did not meet the first two conditions but received licensed residential or outpatient treatment services (excluding detoxification or assessment) during the past 12 months.
4. Individuals who did not meet the first three conditions but used drugs or alcohol “heavily” during the past 18 months. “Heavy” use means drinking an average of four drinks per drinking day at least three to four times per week OR using any illicit drug 50 times during the past 18 months.



Persons Who are Female, Asian, or Hispanic Have LOWER Rates of Current Need for Substance Abuse Treatment. People Who are Male or American Indians* Have HIGHER Rates of Current Treatment Need.

Current Need for Treatment

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*American Indian includes Alaskan Natives.

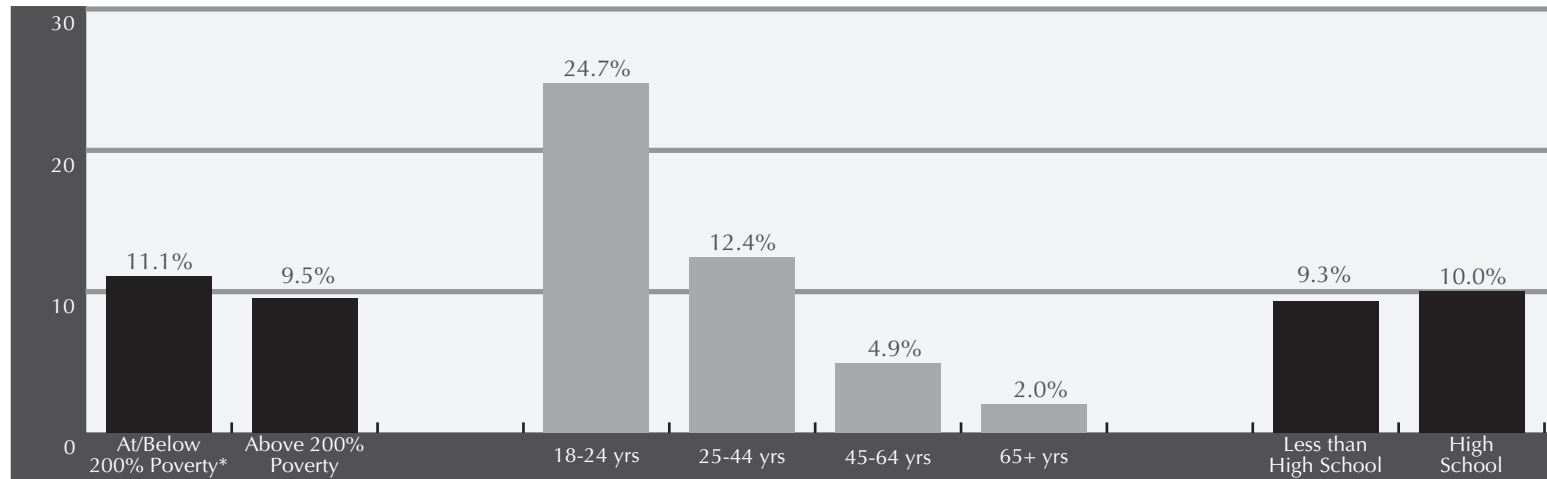
Note: for definition of Current Need for Treatment see page 164.

Persons Who are Age 45 and Older Have LOWER Rates of Current Need for Substance Abuse Treatment.



Current Need for Treatment

Percent of Adults in Household



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

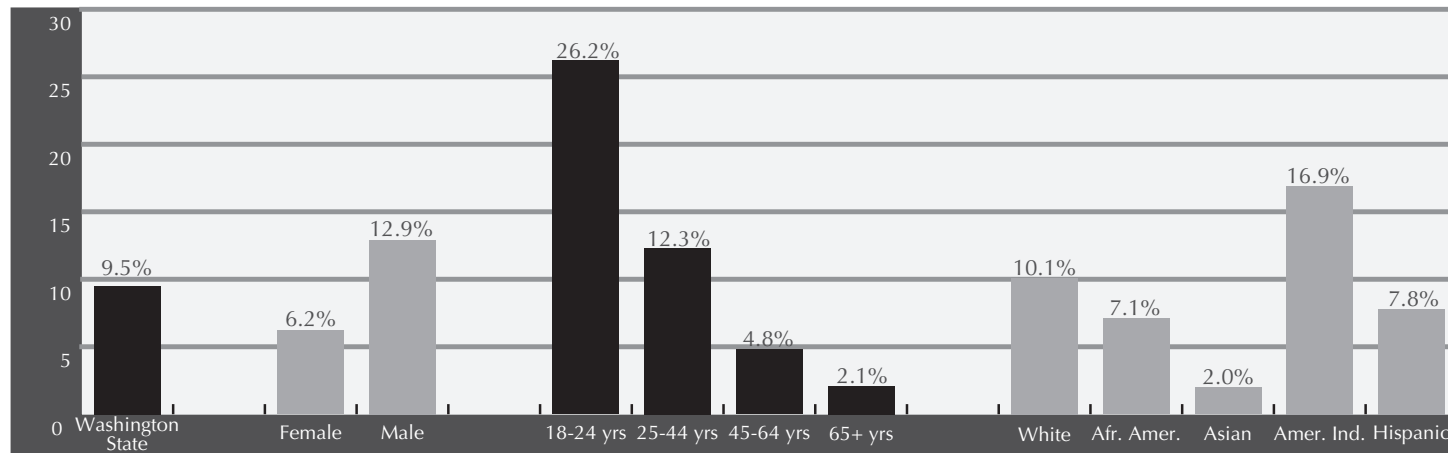
*At/Below 200% of the Federal Poverty Level.

Note: for definition of Current Need for Treatment see page 164.

Adults With Incomes At/Below 200% of the Federal Poverty Level are Slightly More Likely to Have a Current Need for Treatment Than Those With Incomes Above 200% of the Federal Poverty Level.

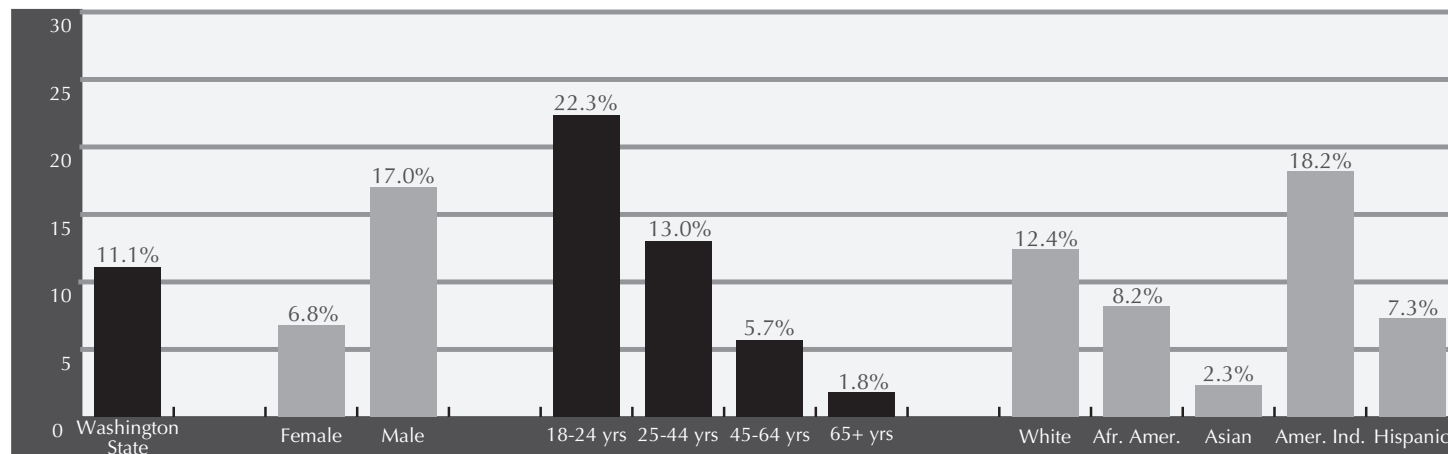
Current Need for Treatment for Adults above 200% of the Federal Poverty Level

Percent of Adults in Households



Current Need for Treatment for Adults at or below 200% of the Federal Poverty Level

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*American Indian includes Alaskan Natives.

Note: for definition of Current Need for Treatment see page 164.

Computing the DASA Treatment Gap



The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially – for DASA-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number. Those receiving BHP with public subsidies would be expected to access chemical dependency treatment services without additional use of DASA funds.

The following equation is then used to compute the DASA Treatment Gap =

$$\text{DASA Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DASA-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DASA-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county number and using the same formula. Counts of persons receiving DASA-funded treatment were drawn from DASA's TARGET management information service. These counts represent cases that were open in SFY 2001. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in households are included. Those residing in institutions or group care settings are excluded from both the numerator and the denominator.* Results by county and statewide are displayed on the following page.

**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*



The Treatment Gap

SFY 2002 Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services

Target Population	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
Adults w/children < 18	45,338	10,125	35,213	77.7%
Adults w/o children under 18	54,525	14,540	39,985	73.3%
ALL ADULTS 18 AND OLDER	99,863	24,665	75,198	75.3%
ADOLESCENTS (AGES 12 - 17)	24,468	5,969	18,499	75.6%
TOTAL	124,331	30,634	93,697	75.4%

Excludes detox and transitional housing, private-pay patients, and Department of Corrections.

**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*

The Treatment Gap: Statewide, in SFY 2002, 75.3% of Adults in Households Who Qualified for and were in Need of DASA-Funded Treatment Did Not Receive It.



County	Number of Adults <200% FPL & eligible for DASA Services	Percent of Adults <200% FPL & in need of Treatment	Number of Adults <200% FPL Receiving Treatment	Number of Adults Not Receiving Treatment	Treatment Gap	
Adams	3,082	7.83%	74	167	69.3%	Adams
Asotin	4,224	11.63%	99	392	79.8%	Asotin
Benton	23,531	10.69%	726	1,789	71.1%	Benton
Chelan	14,461	9.84%	432	991	69.6%	Chelan
Clallam	12,608	9.76%	501	730	59.5%	Clallam
Clark	47,409	11.01%	1,105	4,115	78.8%	Clark
Columbia	882	8.38%	56	18	24.2%	Columbia
Cowlitz	17,913	10.43%	753	1,115	59.7%	Cowlitz
Douglas	6,629	8.64%	113	459	80.3%	Douglas
Ferry	1,775	12.38%	104	116	52.7%	Ferry
Franklin	13,160	7.42%	363	613	62.8%	Franklin
Garfield	365	10.17%	21	16	43.4%	Garfield
Grant	19,512	8.88%	352	1,381	79.7%	Grant
Grays Harbor	16,034	11.51%	350	1,496	81.0%	Grays Harbor
Island	11,170	11.48%	216	1,066	83.2%	Island
Jefferson	5,708	10.79%	138	478	77.6%	Jefferson
King	199,155	11.53%	4,848	18,115	78.9%	King
Kitsap	31,151	11.27%	977	2,534	72.2%	Kitsap
Kittitas	8,125	16.88%	164	1,208	88.0%	Kittitas
Klickitat	4,487	9.44%	145	279	65.8%	Klickitat
Lewis	14,919	10.12%	378	1,132	75.0%	Lewis
Lincoln	1,663	10.62%	47	130	73.4%	Lincoln
Mason	9,223	10.58%	260	716	73.4%	Mason
Okanogan	9,995	10.15%	518	496	48.9%	Okanogan
Pacific	5,235	8.47%	172	271	61.2%	Pacific
Pend Oreille	2,774	9.90%	68	207	75.2%	Pend Oreille
Pierce	111,532	10.55%	2,945	8,822	75.0%	Pierce
San Juan	1,337	10.64%	101	41	29.0%	San Juan
Skagit	14,995	9.67%	576	874	60.3%	Skagit
Skamania	2,122	9.19%	64	131	67.2%	Skamania
Snohomish	63,386	11.29%	1,578	5,578	77.9%	Snohomish
Spokane	82,773	12.78%	1,615	8,963	84.7%	Spokane
Stevens	7,968	11.05%	194	686	78.0%	Stevens
Thurston	31,925	11.48%	848	2,817	76.9%	Thurston
Wahkiakum	660	9.05%	47	13	21.3%	Wahkiakum
Walla Walla	9,395	11.12%	228	817	78.2%	Walla Walla
Whatcom	27,295	14.21%	1,115	2,764	71.3%	Whatcom
Whitman	9,353	20.02%	103	1,769	94.5%	Whitman
Yakima	50,125	8.38%	2,271	1,929	45.9%	Yakima
Total	898,053	11.12%	24,665	75,234	75.3%	

*For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.



Estimates of Substance Use and Treatment Need in Washington State, 2002

	Entire Adult Population	Adult Household Residents	Adults In Household At or Below 200% of Poverty
NEED FOR TREATMENT			
Current Need for Substance Treatment	454,729	426,368	112,379
ALCOHOL OR DRUG DISORDER			
Lifetime Alcohol or Drug Use Disorder	657,813	620,172	156,925
Past 18-Month Alcohol or Drug Use Disorder	339,943	314,393	80,994
ALCOHOL DISORDER			
Lifetime Alcohol Use Disorder	534,026	512,503	118,453
Past 18-Month Alcohol Use Disorder	313,454	292,859	68,845
DRUG DISORDER			
Lifetime Drug Use Disorder	220,742	206,724	68,845
Past 18-Month Drug Use Disorder	79,467	68,908	27,335
ALCOHOL USE			
Lifetime Use of Alcohol	4,079,320	3,975,127	877,768
Past 18-Month Use of Alcohol	3,169,862	3,083,631	583,154
Past 30-Day Use of Alcohol	2,467,901	2,394,551	428,254
USE OF ANY DRUG			
Lifetime Use of Any Illicit Drug	1,792,429	1,731,312	389,782
Past 12-Month Use of Any Illicit Drug	454,729	422,061	112,379
Past 30-Day Use of Any Illicit Drug	229,572	211,031	67,832
MARIJUANA USE			
Lifetime Use of Marijuana	1,721,791	1,662,404	368,521
Past 12-Month Use of Marijuana	419,411	387,607	100,230
Past 30-Day use of Marijuana	220,742	202,417	60,745
STIMULANT USE			
Lifetime Use of Stimulants	741,695	702,000	201,472
Past 12-Month Use of Stimulants	88,297	81,828	30,373
Past 30-Day Use of Stimulants	39,734	34,454	9,112
COCAINE USE			
Lifetime Use of Cocaine	569,516	538,343	128,577
Past 12-Month Use of Cocaine	75,052	68,908	26,323
Past 30-Day Use of Cocaine	26,489	21,534	7,087

Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, *Profile of Substance Use and Need for Treatment Services in Washington State* (1999), estimates updated for 2002.

Estimates of Current Need for Substance Abuse Treatment in Washington State, 2002



GROUP	Entire Adult Population*			Adult Household Residents			Adults In Household at or below 200% Poverty		
	Population	# Needing Treatment	% Needing Treatment	Population	# Needing Treatment	% Needing Treatment	Population	# Needing Treatment	% Needing Treatment
Total	4,414,849	454,520	10.3	4,306,747	422,685	9.8	1,012,420	112,409	11.1
AGE									
01-17	Not Available			Not Available			Not Available		
18-24	572,727	145,702	25.5	529,624	130,585	24.7	197,620	43,984	22.3
25-44	1,714,137	221,079	12.9	1,687,415	208,497	12.4	400,136	51,869	13.0
45-64	1,451,419	72,938	5.0	1,443,059	70,435	4.9	232,287	13,187	5.7
65+	676,566	14,801	2.2	646,649	13,168	2.0	182,376	3,369	1.9
SEX									
Male	2,177,820	312,211	14.3	2,112,056	284,538	13.5	432,412	73,123	16.9
Female	2,237,029	142,310	6.4	2,194,691	138,148	6.3	580,008	39,286	6.8
ETHNICITY									
White	3,738,984	406,882	10.9	3,654,653	381,464	10.4	764,186	94,575	12.4
Black-NH	132,936	12,376	9.3	123,427	9,205	7.5	42,443	3,475	8.2
Asian	246,233	5,221	2.1	241,677	4,930	2.0	70,876	1,643	2.3
Amer. Indian**	58,379	10,664	18.3	56,757	9,875	17.4	26,231	4,766	18.2
Hispanic	238,318	19,377	8.1	230,233	17,211	7.5	108,684	7,950	7.3
MARITAL									
Married	2,696,468	163,371	6.1	2,681,668	160,771	6.0	424,503	29,637	7.0
Div/Sep/Wid	869,488	94,881	10.9	836,075	88,291	10.6	320,115	28,641	9.0
Never Mar	848,894	196,268	23.1	789,005	173,622	22.0	267,802	54,095	20.2
EDUCATION									
Not HS Grad	805,663	78,446	9.7	777,151	72,168	9.3	334,312	19,976	6.0
HS Graduate	3,609,186	376,074	10.4	3,529,597	350,517	9.9	678,107	92,433	13.6
POVERTY									
Below 200%	1,116,101	143,087	12.8	1,012,420	112,409	11.1	1,012,420	112,409	11.1
Above 200%	3,298,748	311,433	9.4	3,294,328	310,276	9.4	-	-	-
RESIDENCE									
Residential	4,306,747	422,685	9.8	4,306,747	422,685	9.8	1,012,420	112,409	11.1
Institutional	51,185	17,715	34.6	-	-	-	-	-	-
Group quarters	56,916	14,121	24.8	-	-	-	-	-	-
*Includes institutions and group quarters									
**American Indian includes Alaskan Native.									

Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, *Profile of Substance Use and Need for Treatment Services in Washington State* (1999), estimates updated for 2002.

Treatment Admission Trends

**Treatment
Admission**

Adult

Youth



Modality categories are defined as follows:

Detoxification

Detoxification is a short-term residential service for individuals withdrawing from the effects of excessive or prolonged alcohol or drug abuse. Services continue only until the person recovers from the transitory effects of acute intoxication. Detoxification always includes supervision and may include counseling and/or medical care and use of pharmacological agents. Some counties provide detoxification in specialized freestanding facilities; in other counties, detoxification is provided in community hospitals.

Intensive Inpatient

Intensive inpatient treatment is a highly structured program for chemically dependent persons in a residential setting. Services emphasize alcohol and drug education and individual and group therapy. The length of stay in intensive inpatient treatment for adults is based on American Society for Addiction Medicine (ASAM) criteria.

Recovery House

Recovery houses provide social, recreational, and occupational therapy as well as treatment in a drug/alcohol-free residential setting. The program emphasizes helping patients re-enter the community and the outpatient phase of treatment.

Long-Term Residential

Long-term residential treatment is a specialized program for chemically dependent persons who require periods of treatment in excess of 90 days. It includes domiciliary care, counseling, and other therapies to patients who reside at the treatment facility.



Other Residential

This category includes transitional housing, residential treatment for co-occurring chemical dependency and mental health disorders, and on-site group care enhancement services for youth.

Transitional housing provides pregnant and parenting women who have completed chemical dependency treatment with up to 18 months of housing. In conjunction with the housing component, women receive case management services that monitor participation in off-site treatment, prepare clients for self-sufficiency, and link women and their children to other needed services.

Co-occurring disorders programs are provided in residential chemical dependency treatment facilities. Utilizing a group care enhancement model, mental health professionals at the facilities provide assessment, education, in-service training for staff, and linkages to mental health providers in the community.

Through group care enhancement contracts, adolescent chemical dependency treatment providers are able to deliver on-site services to children residing in Department of Social and Health Services children's residential facilities. These include select group homes operated by the Division of Children and Family Services, the Mental Health Division, and the Juvenile Rehabilitation Administration. Providers are able to provide individual drug and alcohol assessments; individual, group, and family treatment; prevention and education groups; training of residential agency staff; case planning and consultation, and linkages to other community alcohol and drug services.

Outpatient and Intensive Outpatient Treatment

Outpatient treatment services consist of a variety of diagnostic and treatment services provided according to a prescribed treatment plan in a non-residential setting. Outpatient treatment provided for indigent patients under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) includes vocational counseling and other efforts to help patients regain employment.

Opiate Substitution Treatment

Opiate substitution treatment is an outpatient service for individuals addicted to heroin or other opiates. State-funded and accredited opiate substitution treatment agencies provide counseling and daily or near-daily administration of methadone or other approved substitute drugs.

Treatment Admission Trends

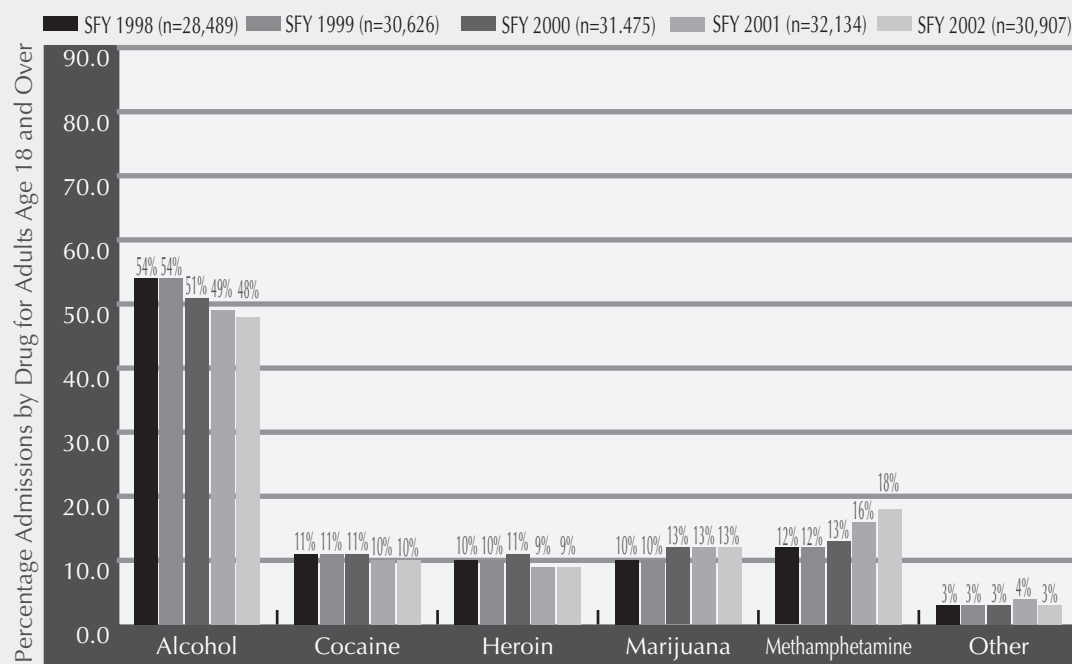
**Treatment
Admission**

Adult

Youth



Alcohol is Cited as the Primary Drug of Abuse in the Plurality of Adult Admissions to DASA-Funded Treatment.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse Department of Social and Health Services.

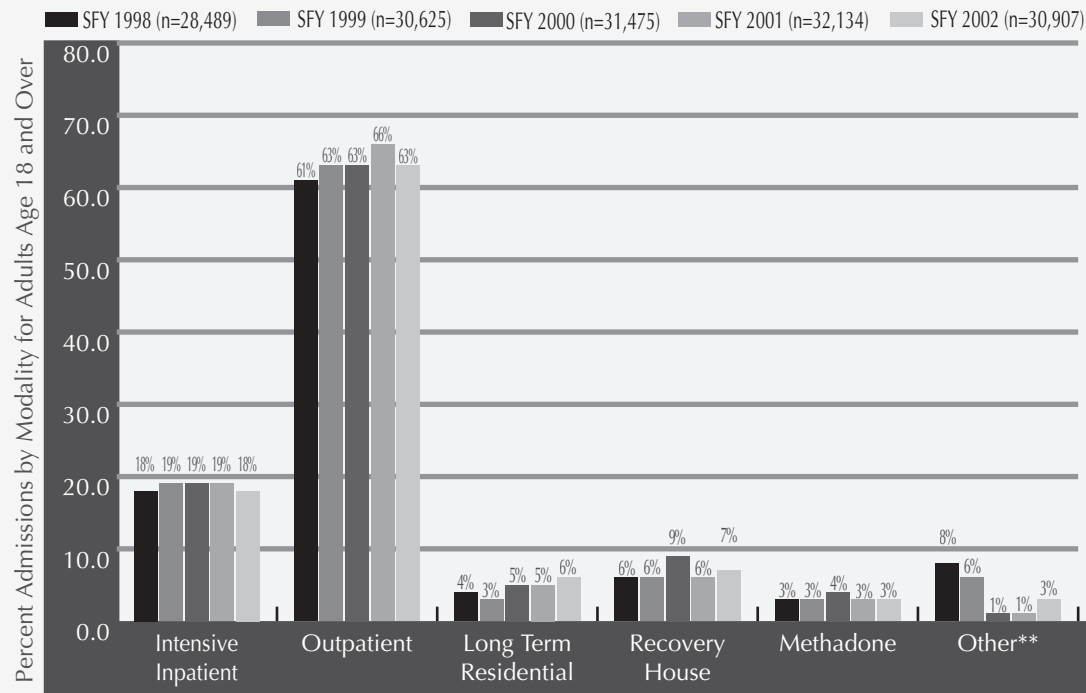
This graph indicates that in SFY 2002, alcohol was the primary drug of abuse for a plurality of adult admissions to DASA-funded treatment. While this has been the case for several decades, in SFY 2001, alcohol-related admissions as a percentage of total admissions dropped below 50% for the first time.

After rising significantly since the early 1990s, the number of admissions to DASA-funded treatment declined by 1,227 or 3.8% between SFY 2001 and SFY 2002. Much of this drop is due to DASA's increased emphasis on treatment retention and completion, which has been demonstrated to result in better outcomes. Without expansion of resources and capacity, it is likely that this decline will continue.

Note: Data may include multiple admissions for a single individual over the course of a year.

*Excludes detoxification and transitional housing

Almost Two-Thirds of Adult Admissions to DASA-Funded Treatment are for Outpatient Services.*



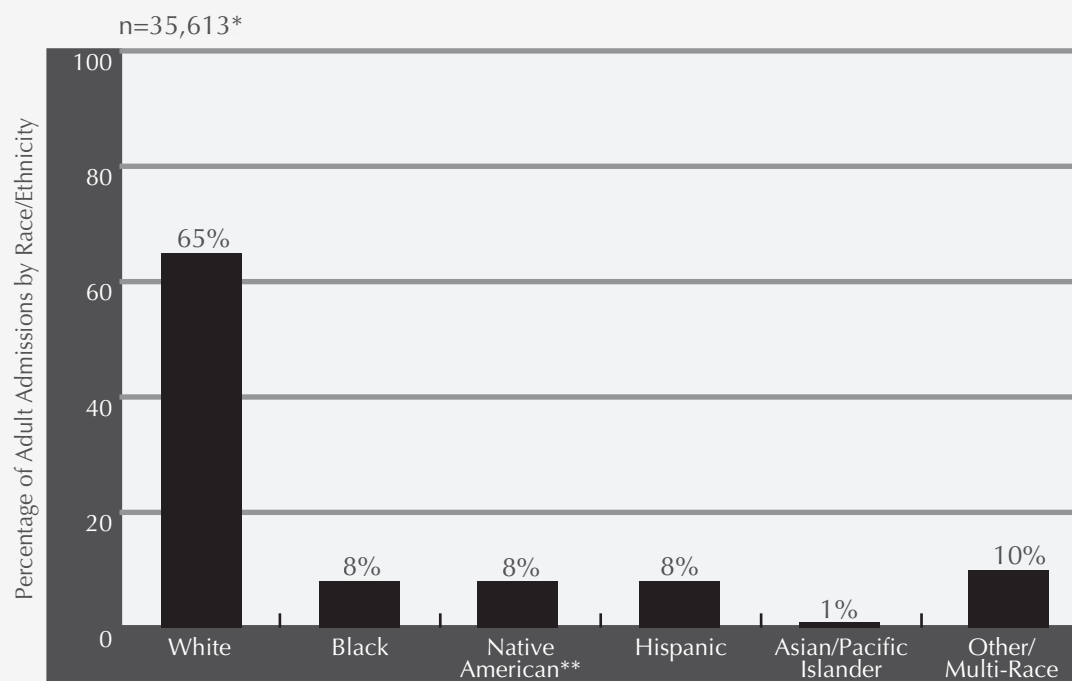
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that almost two-thirds of adults admissions to DASA-funded chemical dependency treatment are for outpatient services (including intensive outpatient treatment). The number of admissions for intensive inpatient treatment has risen 14.3% since SFY 1998.

*Excludes detoxification and transitional housing.

** "Other" includes group care enhancement and treatment services for those with co-occurring disorders. Prior to SFY 2000, "Other" included "Extended Care", a modality that has now been phased out.

In SFY 2002, Racial and Ethnic Minorities Comprised 35% of Adult Admissions to DASA-Funded Chemical Dependency Treatment Services.



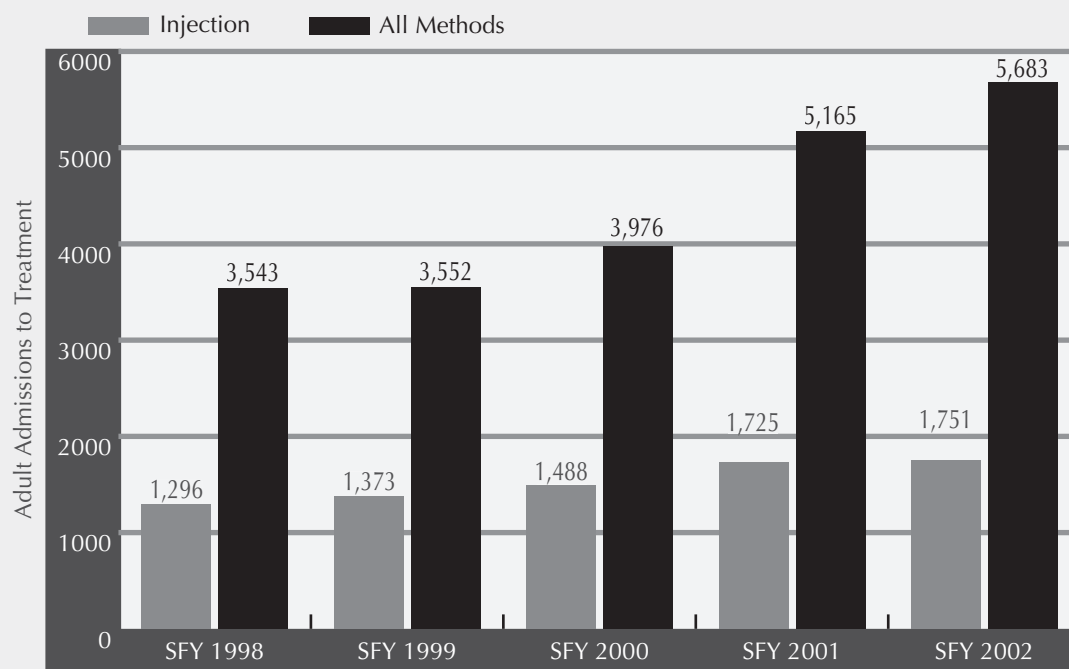
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that racial/ethnic minorities comprise approximately 35% of adult admissions to DASA-funded chemical dependency treatment services. Percentages of adults from different groups receiving DASA-funded treatment vary across modalities.

* In the new U.S. Census, "Hispanic" is listed as an ethnicity, rather than as a racial group. Hence, Hispanic admissions may be duplicated in the racial categories.

** Includes Eskimo/Alaskan Native/Aleut

The Number of Adults Admitted to DASA-Funded Treatment for Methamphetamine Use Continues to Rise.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse Department of Social and Health Services.

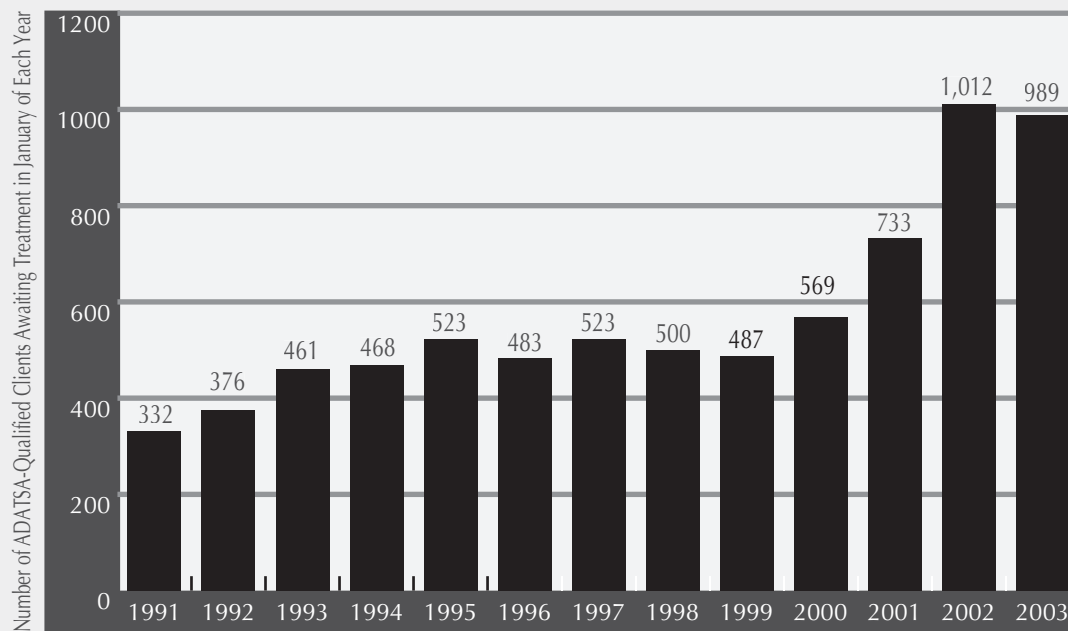
The number of adults admitted to DASA-funded treatment for methamphetamine use continues to rise. Since 1997, when there were 2,224 adults admitted to DASA-funded treatment for methamphetamine, the number of adults admitted has risen 155%.

The majority of adults admitted to DASA-funded treatment for methamphetamine administer the drug via routes other than injection. Injection drug use is closely associated with transmission of HIV and hepatitis B and C. A large majority of methamphetamine users are poly-drug users.

Note: Data excludes detoxification and transitional housing, private-pay and Department of Corrections admissions; admissions are unduplicated.



The Waiting List in Washington State for Treatment Under the Alcohol and Drug Abuse Treatment and Support Act Has Tripled Since 1991.

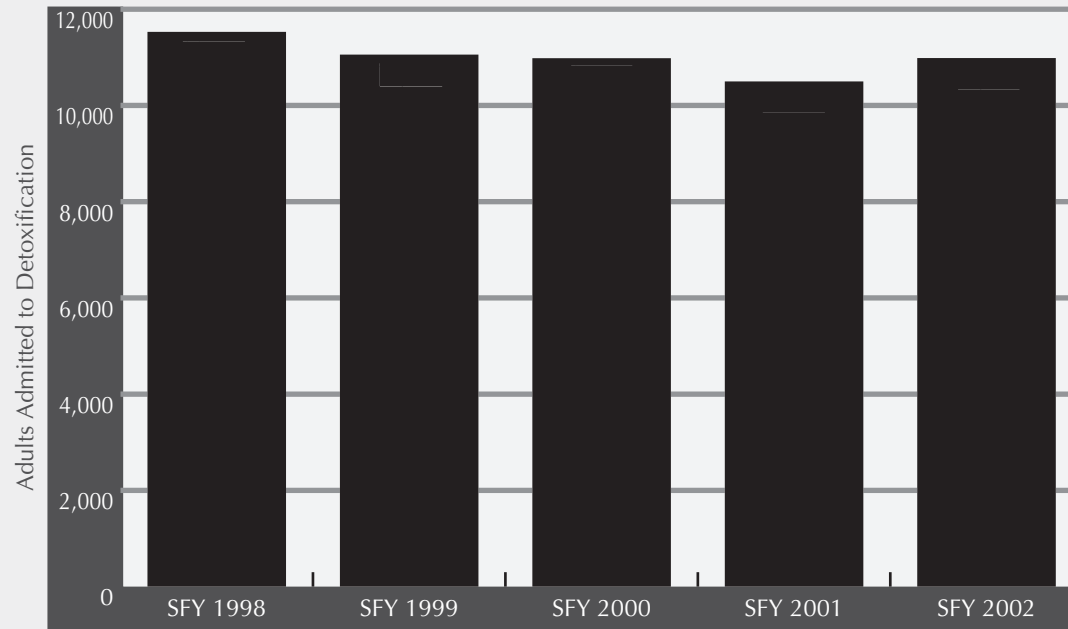


Source: Washington State Division of Alcohol and Substance Abuse.

In 1989, the Washington State Legislature recognized in statute that “alcoholism and drug addiction are treatable diseases, and that most persons with this illness can recover” (RCW 74.50.011). Under the Alcohol and Drug Abuse Treatment and Support Act (ADATSA), assessment, treatment, and support services are provided for individuals who are incapacitated from receipt of gainful employment, and meet specific financial eligibility requirements.

The waiting list for treatment services has tripled since 1991, and the rate of growth has accelerated in the past three years. Some of this growth is attributable to increased emphasis on treatment completion and retention, which has been shown to result in better outcomes. As average patient length of stay increases, correspondingly fewer clients in need are able to access care in a timely manner, assuming no new resources are available for expanding treatment capacity.

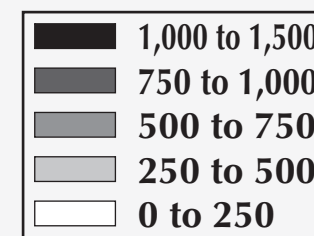
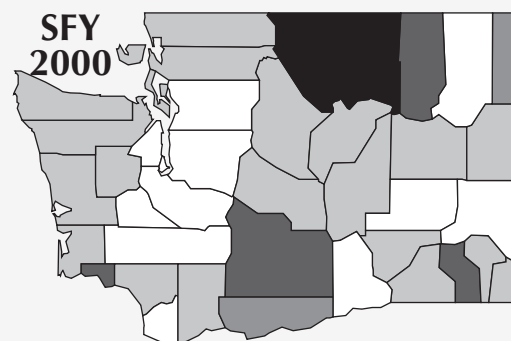
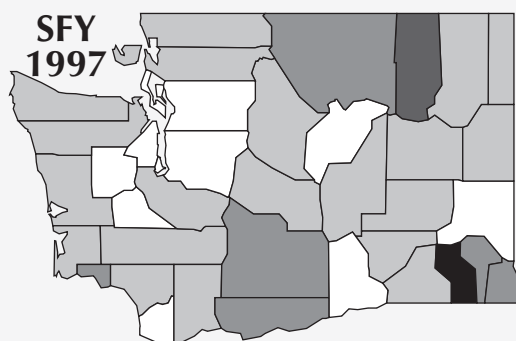
The Number of Adults Receiving DASA-Funded Detoxification Has Remained Relatively Stable.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

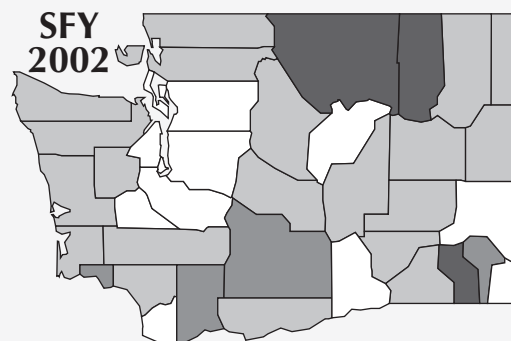
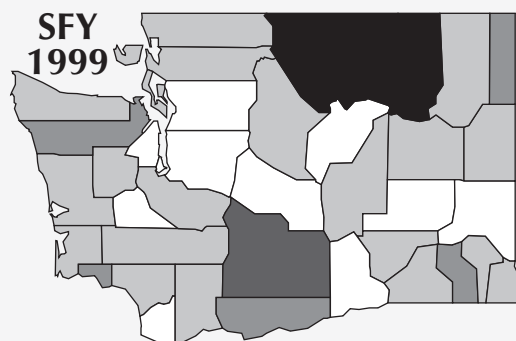
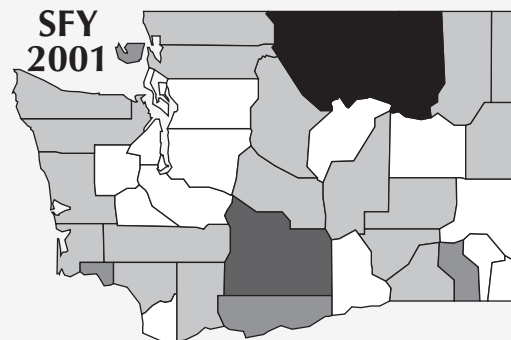
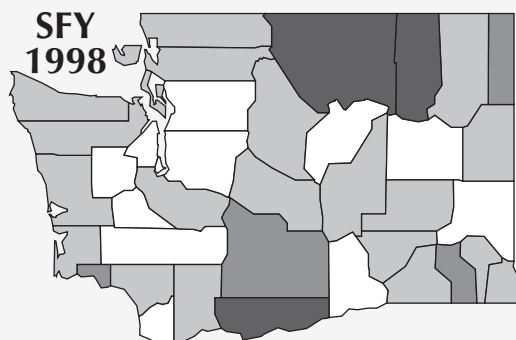
While the overall number of adults undergoing detoxification has remained relatively stable, the number of DASA-funded adult detoxifications for methamphetamine has increased from 458 in SFY 1998 to 832 in SFY 2002, representing an 82% increase. Detoxification is often a necessary precursor to chemical dependency treatment.

Washington State Adult Treatment Admissions for Alcohol Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service





Washington State Adult Treatment Admissions* Primary Drug = Alcohol

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	51	319.0	41	254.8	39	240.9	30	182.6	43	259.0	55	331.1
Asotin	116	572.2	72	346.4	64	310.5	63	306.6	49	236.7	23	111.1
Benton	249	182.4	261	189.3	322	229.3	300	210.6	309	213.4	354	239.8
Chelan	295	447.4	282	424.6	279	417.0	310	465.4	259	386.0	232	343.2
Clallam	226	359.4	257	405.1	261	405.5	268	415.3	319	492.3	236	363.6
Clark	700	220.6	704	214.8	600	177.7	629	182.2	718	203.6	649	178.6
Columbia	56	1,237.0	27	602.1	32	749.1	32	787.4	24	585.4	33	804.9
Cowlitz	334	368.1	270	294.7	366	394.8	425	457.2	440	468.6	384	406.8
Douglas	61	195.2	62	193.5	71	218.3	85	260.7	74	225.6	57	172.2
Ferry	70	982.2	62	880.4	100	1,375.3	69	950.4	79	1,082.2	60	821.9
Franklin	182	385.5	177	370.7	174	360.2	171	346.5	178	353.2	196	382.1
Garfield	14	621.7	8	351.0	9	376.9	7	292.0	1	41.7	12	500.0
Grant	244	346.4	251	347.3	186	252.9	205	274.4	209	275.4	235	307.6
Grays Harbor	276	404.8	267	395.0	274	406.8	237	352.7	217	316.8	214	312.9
Island	167	242.1	185	265.8	197	279.4	207	289.3	151	208.6	153	209.3
Jefferson	102	406.1	86	337.9	143	557.2	87	335.2	80	306.5	71	266.9
King	3413	203.2	3664	215.3	4238	246.4	3929	226.2	3351	190.6	3,100	174.7
Kitsap	519	227.5	346	150.5	395	172.1	373	160.8	374	160.2	559	238.2
Kittitas	86	266.0	95	294.0	85	246.1	98	293.7	113	332.4	103	296.0
Klickitat	111	595.9	160	867.0	101	537.4	135	704.6	113	585.5	80	414.5
Lewis	208	308.8	155	228.2	183	267.0	149	217.2	168	241.7	210	299.1
Lincoln	26	263.1	24	238.1	29	285.9	46	451.7	29	284.3	26	254.9
Mason	78	165.0	98	204.5	149	307.1	182	368.4	122	246.0	141	283.1
Okanogan	281	697.7	377	956.2	496	1,258.0	452	1,142.5	457	1,151.1	314	788.9
Pacific	86	413.2	72	344.0	57	271.7	75	357.4	62	295.2	99	471.4
Pend Oreille	50	423.2	64	540.2	80	686.5	81	690.4	58	491.5	54	457.6
Pierce	1781	266.6	1869	274.7	1940	280.5	1495	213.3	1457	204.2	1,290	177.9
San Juan	44	340.9	51	385.2	51	363.8	53	376.5	74	513.9	50	342.5
Skagit	453	463.0	479	479.7	470	460.5	460	446.7	484	464.9	356	338.7
Skamania	35	366.1	32	334.7	29	302.6	33	334.3	30	303.0	57	575.8
Snohomish	1183	212.4	1168	202.7	1437	242.9	1491	246.0	1477	238.8	1,018	162.1
Spokane	1196	292.0	1083	261.9	1138	273.1	1214	290.5	1317	311.8	1,116	262.2
Stevens	109	289.8	114	299.0	118	304.4	97	242.1	112	277.9	131	324.3
Thurston	439	220.5	384	189.7	353	171.7	410	197.7	392	186.5	457	215.3
Wahkiakum	26	669.6	22	566.3	23	593.5	36	941.4	25	657.9	23	605.3
Walla Walla	165	298.7	169	304.4	184	333.9	171	309.9	184	333.3	146	263.5
Whatcom	684	434.4	703	438.8	777	473.0	782	468.8	815	477.7	736	427.4
Whitman	31	76.0	62	151.0	68	165.1	79	193.9	71	176.2	55	135.5
Yakima	1340	598.4	1521	682.6	1998	893.6	1904	855.4	1959	872.6	1,472	654.2
Total	15,487	273.4	15,724	273.5	17,516	300.4	16,870	286.2	16,394	274.4	14,557	240.9

* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Marijuana Per 100,000 in Population



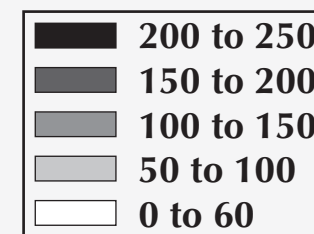
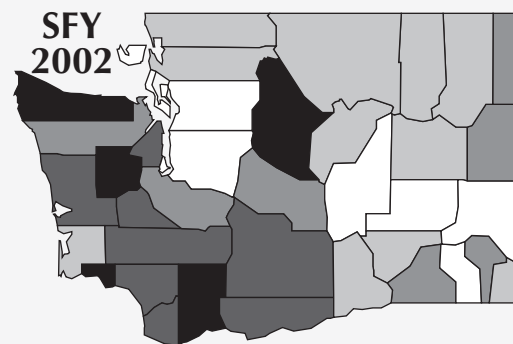
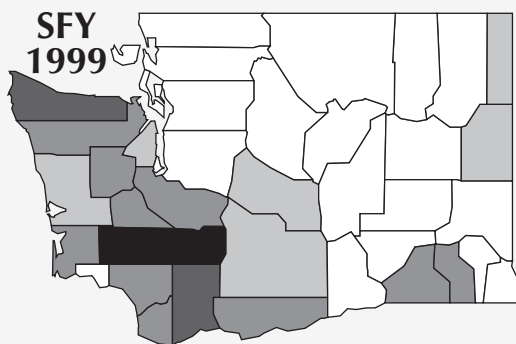
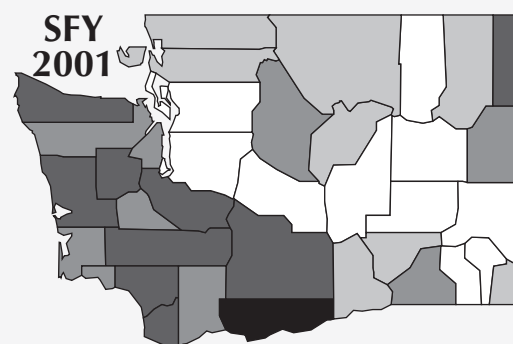
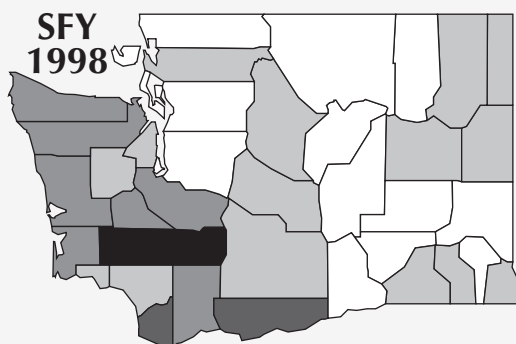
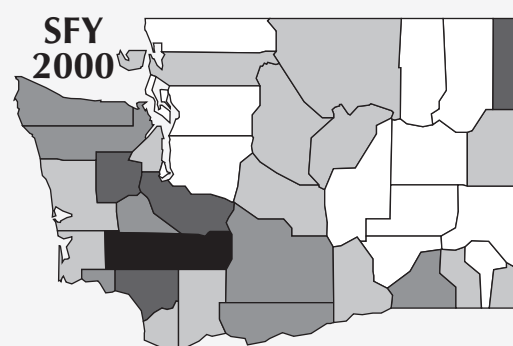
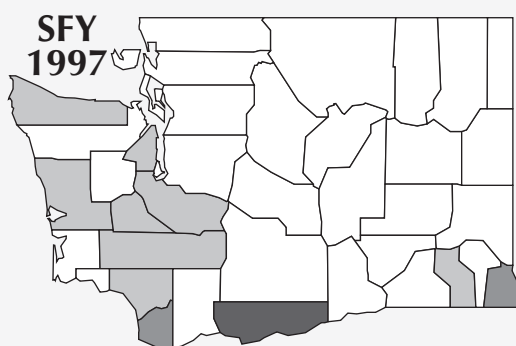


Washington State Adult Treatment Admissions* Primary Drug = Marijuana

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	4	25.0	2	12.4	1	6.2	2	12.2	9	54.2	2	12.0
Asotin	26	128.2	15	72.2	12	58.2	13	63.3	14	67.6	18	87.0
Benton	58	42.5	66	47.9	93	66.2	86	60.4	121	83.6	111	75.2
Chelan	47	71.3	69	103.9	62	92.7	50	75.1	77	114.8	68	100.6
Clallam	34	54.1	52	82.0	73	113.4	91	141.0	125	192.9	80	123.3
Clark	162	51.1	155	47.3	210	62.2	194	56.2	307	87.1	214	58.9
Columbia	5	110.4	7	156.1	3	70.2	4	98.4	5	122.0	7	170.7
Cowlitz	75	82.7	72	78.6	67	72.3	106	114.0	100	106.5	81	85.8
Douglas	11	35.2	7	21.8	14	43.0	18	55.2	17	51.8	12	36.3
Ferry	13	182.4	7	99.4	16	220.1	9	124.0	9	123.3	11	150.7
Franklin	23	48.7	18	37.7	32	66.2	26	52.7	31	61.5	43	83.8
Garfield	5	222.0	0	0.0	0	0.0	0	0.0	1	41.7	3	125.0
Grant	42	59.6	33	45.7	38	51.7	42	56.2	28	36.9	56	73.3
Grays Harbor	61	89.5	53	78.4	56	83.1	47	69.9	51	74.5	77	112.6
Island	23	33.3	25	35.9	28	39.7	49	68.5	28	38.7	25	34.2
Jefferson	18	71.7	27	106.1	27	105.2	22	84.8	26	99.6	21	78.9
King	388	23.1	492	28.9	644	37.4	741	42.7	761	43.3	611	34.4
Kitsap	121	53.0	90	39.2	105	45.7	92	39.7	129	55.3	148	63.1
Kittitas	16	49.5	23	71.2	18	52.1	27	80.9	16	47.1	19	54.6
Klickitat	21	112.7	39	211.3	27	143.7	30	156.6	35	181.3	15	77.7
Lewis	42	62.4	40	58.9	74	108.0	76	110.8	72	103.6	55	78.3
Lincoln	7	70.8	5	49.6	6	59.1	6	58.9	7	68.6	3	29.4
Mason	20	42.3	15	31.3	26	53.6	46	93.1	45	90.7	25	50.2
Okanogan	19	47.2	24	60.9	25	63.4	45	113.7	51	128.5	38	95.5
Pacific	12	57.7	33	157.7	20	95.3	19	90.5	25	119.0	21	100.0
Pend Oreille	5	42.3	11	92.8	21	180.2	17	144.9	9	76.3	11	93.2
Pierce	331	49.5	424	62.3	546	79.0	578	82.5	591	82.8	426	58.8
San Juan	10	77.5	10	75.5	8	57.1	15	106.6	26	180.6	16	109.6
Skagit	72	73.6	74	74.1	100	98.0	119	115.6	128	123.0	116	110.4
Skamania	11	115.1	8	83.7	11	114.8	12	121.6	12	121.2	8	80.8
Snohomish	165	29.6	200	34.7	258	43.6	383	63.2	387	62.6	265	42.2
Spokane	261	63.7	230	55.6	308	73.9	373	89.2	397	94.0	264	62.0
Stevens	12	31.9	31	81.3	26	67.1	30	74.9	30	74.4	29	71.8
Thurston	121	60.8	75	37.1	92	44.8	135	65.1	138	65.7	174	82.0
Wahkiakum	3	77.3	3	77.2	7	180.6	8	209.2	3	78.9	4	105.3
Walla Walla	27	48.9	36	64.8	41	74.4	60	108.7	72	130.4	28	50.5
Whatcom	80	50.8	99	61.8	123	74.9	116	69.5	177	103.8	172	99.9
Whitman	18	44.1	11	26.8	9	21.8	14	34.4	25	62.0	14	34.5
Yakima	233	104.1	326	146.3	446	199.5	497	223.3	562	250.3	447	198.7
Total	2,602	45.9	2,907	50.6	3,673	63.0	4,198	71.2	4,647	77.8	3,738	61.9

* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service

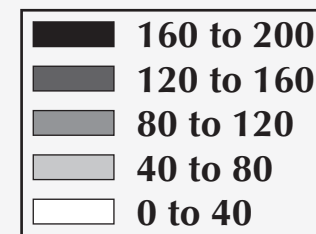
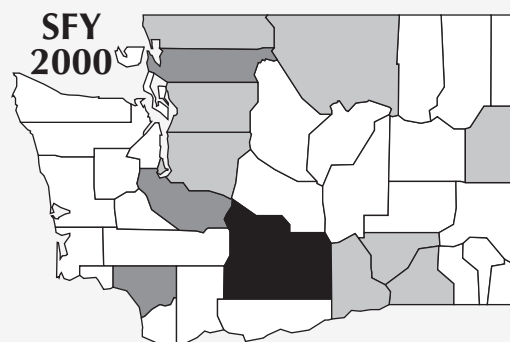
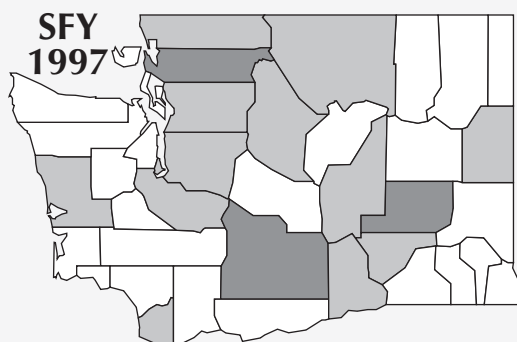


Washington State Adult Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.3	4	24.9	1	6.2	3	18.3	0	0.0	5	30.1
Asotin	21	103.6	17	81.8	10	48.5	16	77.9	20	96.6	21	101.4
Benton	61	44.7	55	39.9	69	49.1	87	61.1	131	90.5	165	111.8
Chelan	18	27.3	35	52.7	20	29.9	44	66.1	75	111.8	137	202.7
Clallam	48	76.3	72	113.5	100	155.4	91	141.0	105	162.0	152	234.2
Clark	356	112.2	546	166.6	478	141.6	493	142.8	679	192.6	576	158.5
Columbia	4	88.4	3	66.9	5	117.0	3	73.8	2	48.8	1	24.4
Cowlitz	73	80.5	71	77.5	130	140.2	169	181.8	181	192.8	185	196.0
Douglas	4	12.8	13	40.6	13	40.0	22	67.5	22	67.1	33	99.7
Ferry	3	42.1	0	0.0	0	0.0	0	0.0	3	41.1	5	68.5
Franklin	13	27.5	9	18.8	23	47.6	18	36.5	36	71.4	29	56.5
Garfield	0	0.0	0	0.0	1	41.9	0	0.0	0	0.0	4	166.7
Grant	16	22.7	14	19.4	11	15.0	12	16.1	22	29.0	36	47.1
Grays Harbor	59	86.5	86	127.2	56	83.1	59	87.8	105	153.3	126	184.2
Island	3	4.3	16	23.0	13	18.4	20	27.9	34	47.0	32	43.8
Jefferson	7	27.9	31	121.8	38	148.1	32	123.3	32	122.6	28	105.3
King	234	13.9	363	21.3	397	23.1	454	26.1	580	33.0	659	37.1
Kitsap	141	61.8	196	85.3	178	77.5	206	88.8	271	116.1	363	154.7
Kittitas	12	37.1	23	71.2	21	60.8	30	89.9	14	41.2	43	123.6
Klickitat	36	193.3	32	173.4	24	127.7	21	109.6	48	248.7	34	176.2
Lewis	65	96.5	137	201.7	168	245.1	152	221.6	118	169.8	136	193.7
Lincoln	2	20.2	6	59.5	1	9.9	3	29.5	2	19.6	10	98.0
Mason	20	42.3	31	64.7	55	113.4	75	151.8	88	177.4	108	216.9
Okanogan	2	5.0	11	27.9	12	30.4	20	50.6	24	60.5	21	52.8
Pacific	4	19.2	22	105.1	22	104.9	11	52.4	26	123.8	33	157.1
Pend Oreille	1	8.5	10	84.4	8	68.6	22	187.5	19	161.0	13	110.2
Pierce	472	70.6	798	117.3	969	140.1	1108	158.1	1272	178.3	1079	148.8
San Juan	4	31.0	4	30.2	4	28.5	8	56.8	8	55.6	7	47.9
Skagit	26	26.6	64	64.1	41	40.2	72	69.9	99	95.1	103	98.0
Skamania	4	41.8	13	136.0	16	166.9	8	81.0	11	111.1	42	424.2
Snohomish	106	19.0	181	31.4	212	35.8	244	40.3	279	45.1	301	47.9
Spokane	170	41.5	227	54.9	294	70.6	372	89.0	522	123.6	462	108.6
Stevens	14	37.2	21	55.1	19	49.0	19	47.4	23	57.1	23	56.9
Thurston	110	55.3	245	121.1	209	101.7	222	107.1	265	126.1	342	161.1
Wahkiakum	0	0.0	3	77.2	1	25.8	5	130.8	5	131.6	10	263.2
Walla Walla	24	43.4	55	99.1	60	108.9	68	123.2	59	106.9	66	119.1
Whatcom	24	15.2	30	18.7	50	30.4	74	44.4	92	53.9	142	82.5
Whitman	5	12.3	8	19.5	7	17.0	6	14.7	10	24.8	19	46.8
Yakima	55	24.6	165	74.0	219	97.9	241	108.3	418	186.2	379	168.4
Total	2,218	39.2	3,617	62.9	3,955	67.8	4,510	76.5	5,700	95.4	5,930	98.2

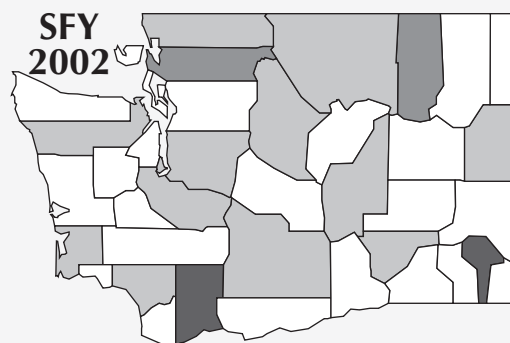
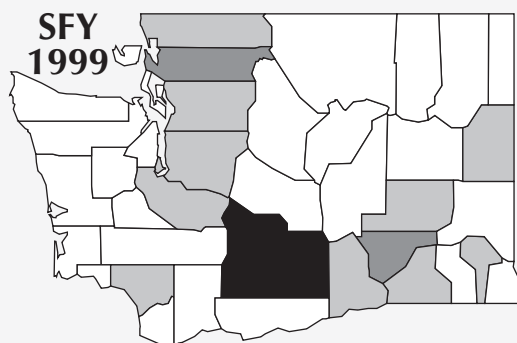
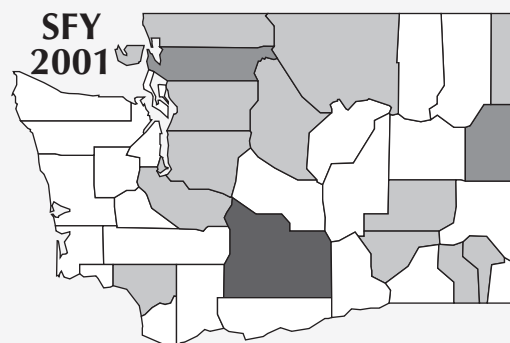
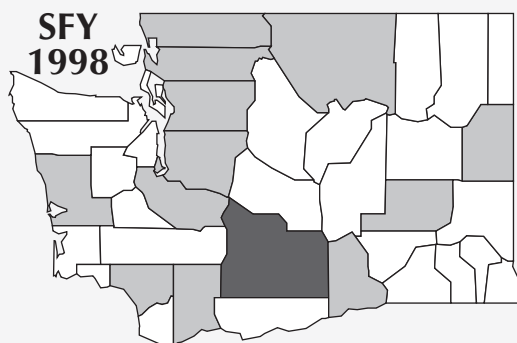
* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Cocaine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



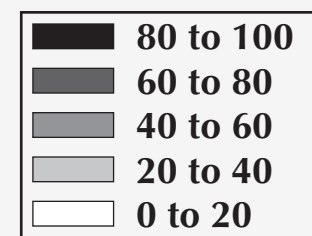
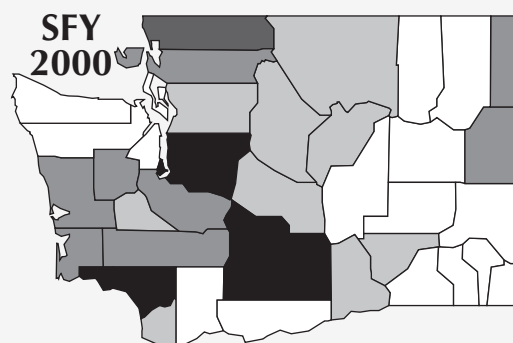
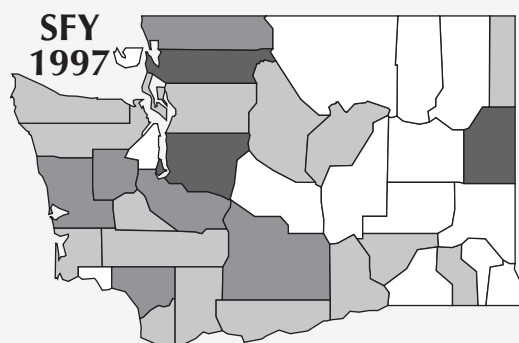


Washington State Adult Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	18	112.6	10	62.1	8	49.4	6	36.5	8	48.2	4	24.1
Asotin	4	19.7	1	4.8	3	14.6	2	9.7	1	4.8	0	0.0
Benton	55	40.3	37	26.8	77	54.8	57	40.0	53	36.6	46	31.2
Chelan	35	53.1	29	43.7	18	26.9	21	31.5	27	40.2	28	41.4
Clallam	16	25.4	10	15.8	20	31.1	14	21.7	16	24.7	14	21.6
Clark	166	52.3	128	39.0	117	34.7	84	24.3	109	30.9	116	31.9
Columbia	0	0.0	1	22.3	0	0.0	1	24.6	2	48.8	0	0.0
Cowlitz	70	77.2	55	60.0	46	49.6	83	89.3	71	75.6	51	54.0
Douglas	7	22.4	5	15.6	4	12.3	12	36.8	7	21.3	6	18.1
Ferry	0	0.0	1	14.2	1	13.8	1	13.8	0	0.0	6	82.2
Franklin	31	65.7	15	31.4	43	89.0	31	62.8	33	65.5	30	58.5
Garfield	0	0.0	0	0.0	1	41.9	0	0.0	1	41.7	3	125.0
Grant	38	54.0	26	36.0	21	28.6	28	37.5	20	26.4	40	52.4
Grays Harbor	49	71.9	39	57.7	25	37.1	16	23.8	20	29.2	7	10.2
Island	11	15.9	12	17.2	15	21.3	13	18.2	10	13.8	10	13.7
Jefferson	4	15.9	3	11.8	2	7.8	1	3.9	3	11.5	11	41.4
King	1167	69.5	1138	66.9	1372	79.8	1386	79.8	1223	69.6	974	54.9
Kitsap	89	39.0	44	19.1	47	20.5	53	22.8	53	22.7	61	26.0
Kittitas	8	24.7	3	9.3	2	5.8	7	21.0	4	11.8	5	14.4
Klickitat	5	26.8	6	32.5	2	10.6	4	20.9	3	15.5	1	5.2
Lewis	5	7.4	8	11.8	6	8.8	10	14.6	3	4.3	2	2.8
Lincoln	1	10.1	1	9.9	3	29.6	1	9.8	1	9.8	1	9.8
Mason	3	6.3	11	23.0	13	26.8	11	22.3	14	28.2	8	16.1
Okanogan	19	47.2	21	53.3	10	25.4	19	48.0	23	57.9	17	42.7
Pacific	6	28.8	6	28.7	5	23.8	5	23.8	4	19.0	12	57.1
Pend Oreille	2	16.9	3	25.3	1	8.6	2	17.0	6	50.8	2	16.9
Pierce	493	73.8	521	76.6	641	92.7	577	82.3	514	72.0	416	57.4
San Juan	4	31.0		0.0		0.0	3	21.3	9	62.5	5	34.2
Skagit	97	99.1	69	69.1	111	108.7	119	115.6	98	94.1	88	83.7
Skamania	3	31.4	4	41.8	1	10.4	1	10.1	2	20.2	15	151.5
Snohomish	312	56.0	350	60.7	377	63.7	355	58.6	351	56.7	243	38.7
Spokane	277	67.6	242	58.5	296	71.0	301	72.0	348	82.4	238	55.9
Stevens	10	26.6	2	5.2	6	15.5	9	22.5	4	9.9	8	19.8
Thurston	54	27.1	33	16.3	53	25.8	56	27.0	45	21.4	59	27.8
Wahkiakum	0	0.0	0	0.0	0	0.0	1	26.2	0	0.0	0	0.0
Walla Walla	10	18.1	12	21.6	25	45.4	23	41.7	16	29.0	8	14.4
Whatcom	74	47.0	87	54.3	81	49.3	99	59.3	105	61.5	87	50.5
Whitman	1	2.5	1	2.4	1	2.4	2	4.9	9	22.3	8	19.7
Yakima	268	119.7	297	133.3	400	178.9	365	164.0	359	159.9	280	124.4
Total	3,412	60.2	3,231	56.2	3,854	66.1	3,779	64.1	3,575	59.8	2,910	48.2

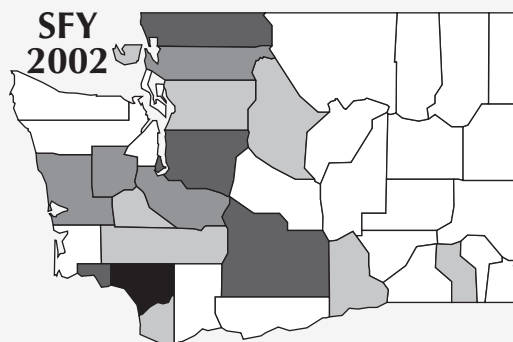
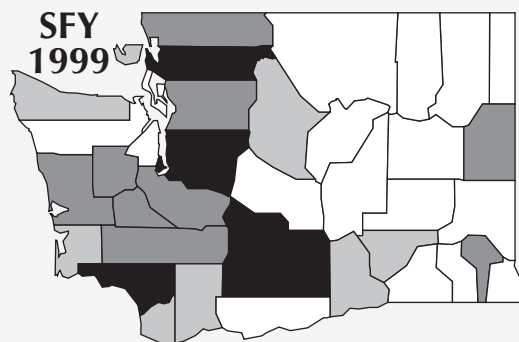
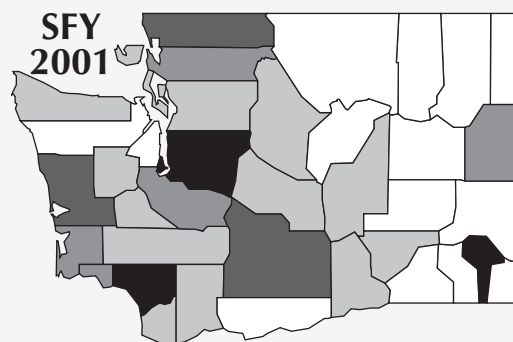
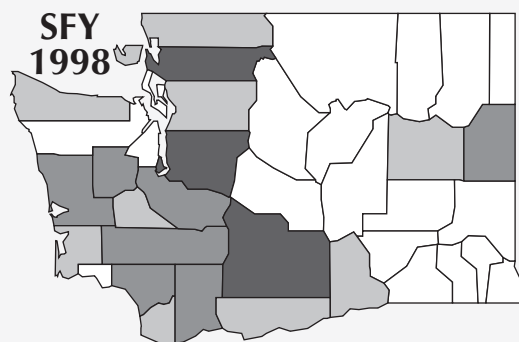
* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Heroin Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service





Washington State Adult Treatment Admissions* Primary Drug = Heroin

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	0	0.0	2	12.4	1	6.1	2	12.0	1	6.0
Asotin	4	19.7	4	19.2	2	9.7	3	14.6	4	19.3	0	0.0
Benton	39	28.6	47	34.1	55	39.2	33	23.2	34	23.5	31	21.0
Chelan	21	31.8	11	16.6	15	22.4	23	34.5	25	37.3	16	23.7
Clallam	15	23.9	19	29.9	20	31.1	12	18.6	14	21.6	8	12.3
Clark	89	28.0	130	39.7	118	35.0	113	32.7	125	35.5	131	36.0
Columbia	1	22.1	0	0.0	0	0.0	0	0.0	0	0.0	1	24.4
Cowlitz	40	44.1	53	57.9	86	92.8	158	170.0	93	99.0	89	94.3
Douglas	7	22.4	7	21.8	3	9.2	8	24.5	5	15.2	4	12.1
Ferry	0	0.0	1	14.2	0	0.0	1	13.8	0	0.0	0	0.0
Franklin	11	23.3	9	18.8	16	33.1	16	32.4	16	31.7	9	17.5
Garfield	0	0.0	0	0.0	1	41.9	0	0.0	2	83.3	0	0.0
Grant	12	17.0	11	15.2	10	13.6	8	10.7	22	29.0	5	6.5
Grays Harbor	29	42.5	29	42.9	33	49.0	39	58.0	45	65.7	31	45.3
Island	19	27.5	8	11.5	11	15.6	8	11.2	16	22.1	5	6.8
Jefferson	6	23.9	2	7.9	5	19.5	2	7.7	4	15.3	2	7.5
King	1298	77.3	1322	77.7	1382	80.3	1807	104.0	1406	80.0	1200	67.7
Kitsap	33	14.5	35	15.2	34	14.8	28	12.1	27	11.6	37	15.8
Kittitas	3	9.3	3	9.3	3	8.7	9	27.0	8	23.5	3	8.6
Klickitat	4	21.5	4	21.7	2	10.6	2	10.4	2	10.4	0	0.0
Lewis	18	26.7	34	50.1	38	55.4	30	43.7	17	24.5	20	28.5
Lincoln		0.0	3	29.8	1	9.9	1	9.8	0	0.0	1	9.8
Mason	21	44.4	24	50.1	25	51.5	27	54.7	19	38.3	22	44.2
Okanogan	5	12.4	5	12.7	1	2.5	8	20.2	3	7.6	2	5.0
Pacific	7	33.6	5	23.9	8	38.1	11	52.4	11	52.4	4	19.0
Pend Oreille	3	25.4	1	8.4	1	8.6	5	42.6	1	8.5	0	0.0
Pierce	376	56.3	405	59.5	396	57.3	342	48.8	414	58.0	367	50.6
San Juan	1	7.7	4	30.2	4	28.5	7	49.7	5	34.7	4	27.4
Skagit	60	61.3	68	68.1	92	90.1	60	58.3	55	52.8	46	43.8
Skamania	2	20.9	5	52.3	2	20.9	0	0.0	3	30.3	1	10.1
Snohomish	186	33.4	159	27.6	272	46.0	230	38.0	195	31.5	151	24.0
Spokane	246	60.1	207	50.1	201	48.2	246	58.9	223	52.8	174	40.9
Stevens	6	16.0	2	5.2	3	7.7	4	10.0	3	7.4	4	9.9
Thurston	76	38.2	76	37.6	108	52.5	71	34.2	78	37.1	83	39.1
Wahkiakum	0	0.0	0	0.0	5	129.0	6	156.9	2	52.6	3	78.9
Walla Walla	6	10.9	4	7.2	9	16.3	9	16.3	6	10.9	4	7.2
Whatcom	80	50.8	74	46.2	71	43.2	114	68.3	123	72.1	120	69.7
Whitman	0	0.0	0	0.0	2	4.9	0	0.0	0	0.0	0	0.0
Yakima	128	57.2	175	78.5	195	87.2	222	99.7	164	73.1	176	78.2
Total	2,852	50.4	2,946	51.2	3,232	55.4	3,664	62.2	3,172	53.1	2,755	45.6

* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Admission Trends

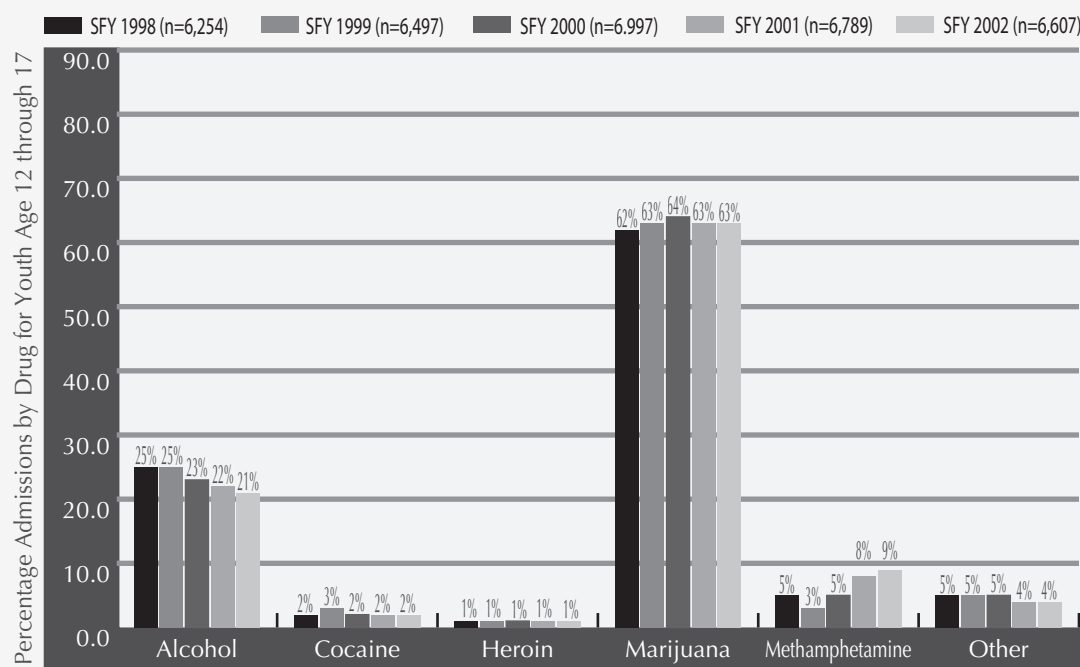
**Treatment
Admission**

Adult

Youth



Marijuana is the Most Frequently Cited Primary Drug of Abuse in Youth Admissions to DASA-Funded Treatment.*



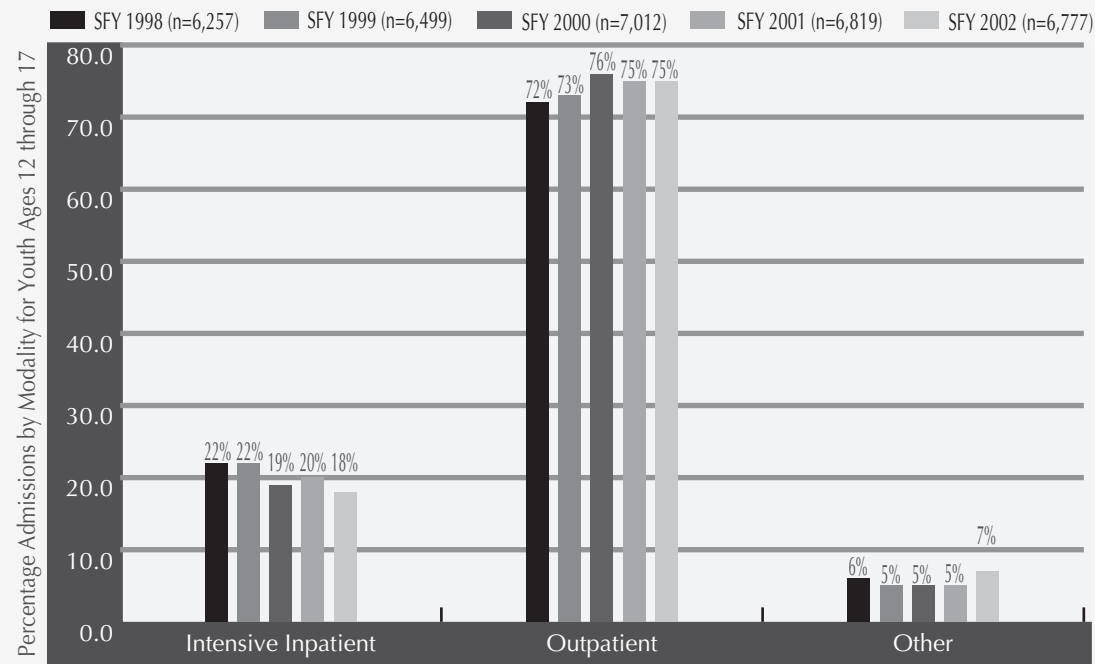
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that for the past five years, marijuana was the primary drug of abuse for a plurality of youth admissions to DASA-funded treatment. Youth admissions for methamphetamine abuse have almost doubled in the same period, from 319 in SFY 1998 to 611 in SFY 2002.

Note: Data may include multiple admissions for a single individual over the course of a year.

*Excludes detoxification and transitional housing.

The Majority of Youth Admissions to DASA-Funded Chemical Dependency Treatment are for Outpatient Services.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

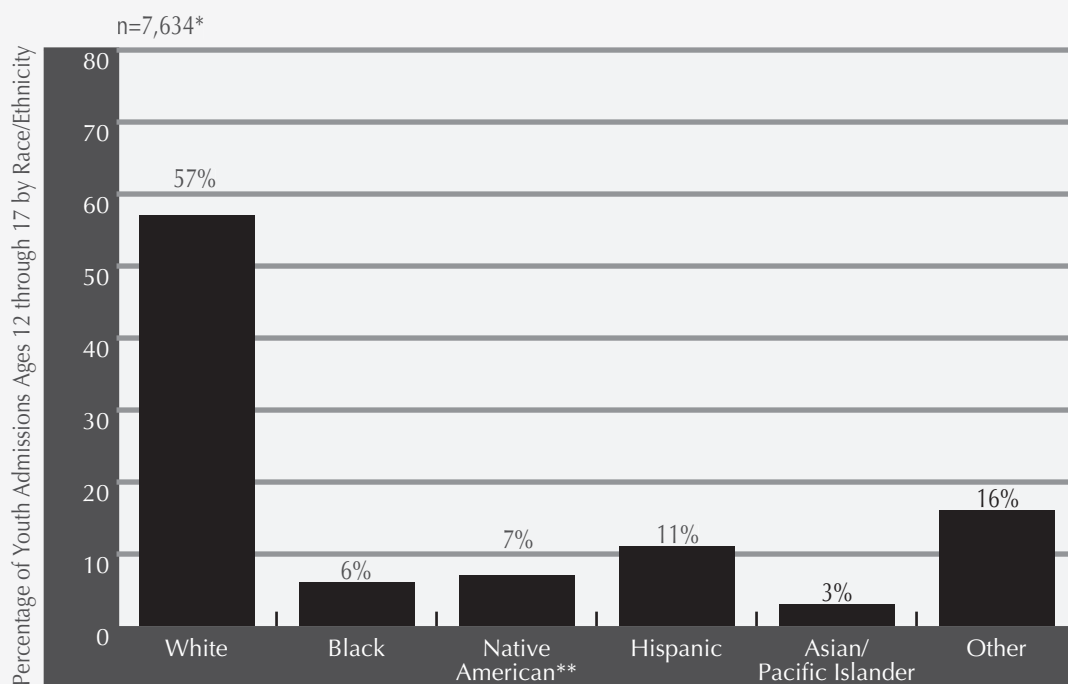
Three-quarters of youth admissions to DASA-funded chemical dependency treatment services are for outpatient treatment (including intensive outpatient).

Note: Data may include multiple admissions for a single individual over the course of a year. "Other" includes group care enhancement, recovery house, long-term residential, methadone, and treatment services for those with co-occurring disorders.

*Excludes detoxification and transitional housing.



In SFY 2002, Racial and Ethnic Minorities Comprised 43% of Youth Admissions to DASA-Funded Chemical Dependency Treatment Services.



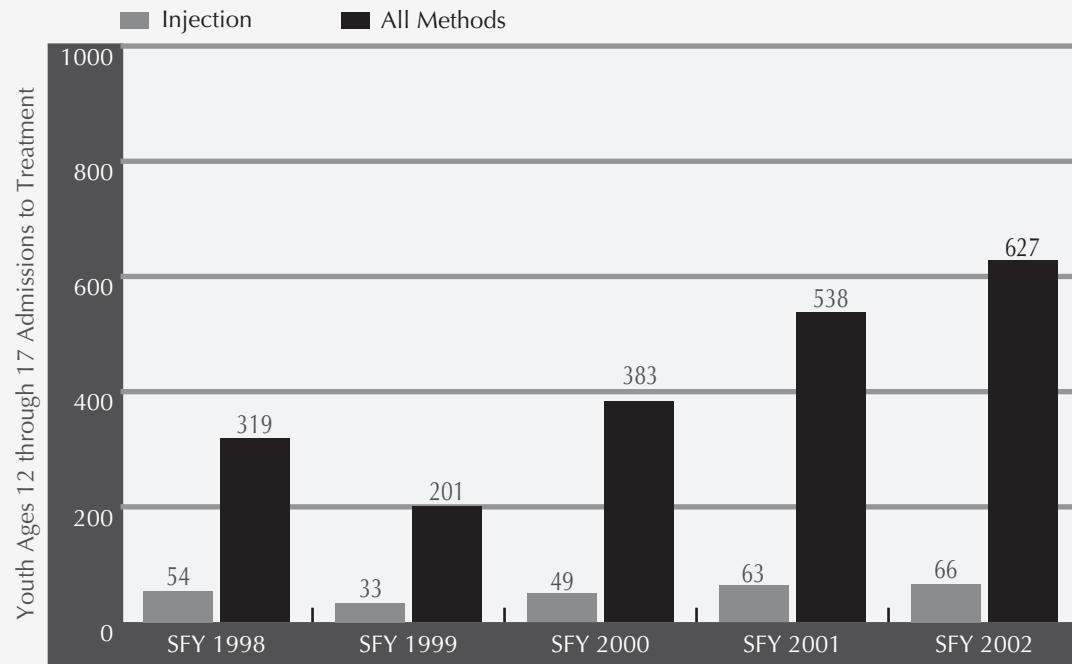
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that racial/ethnic minorities comprise approximately 43% of youth admissions to DASA-funded chemical dependency treatment services. Percentages of youth from different groups receiving DASA-funded treatment vary across modalities.

* In the new U.S. Census, "Hispanic" is listed as an ethnicity, rather than as a racial group. Hence, Hispanic admissions may be duplicated in the racial categories.

**Includes Eskimo/Alaskan Native/Aleut

DASA-Funded Youth Treatment Admissions for Methamphetamine Use Have Quadrupled Since 1997.



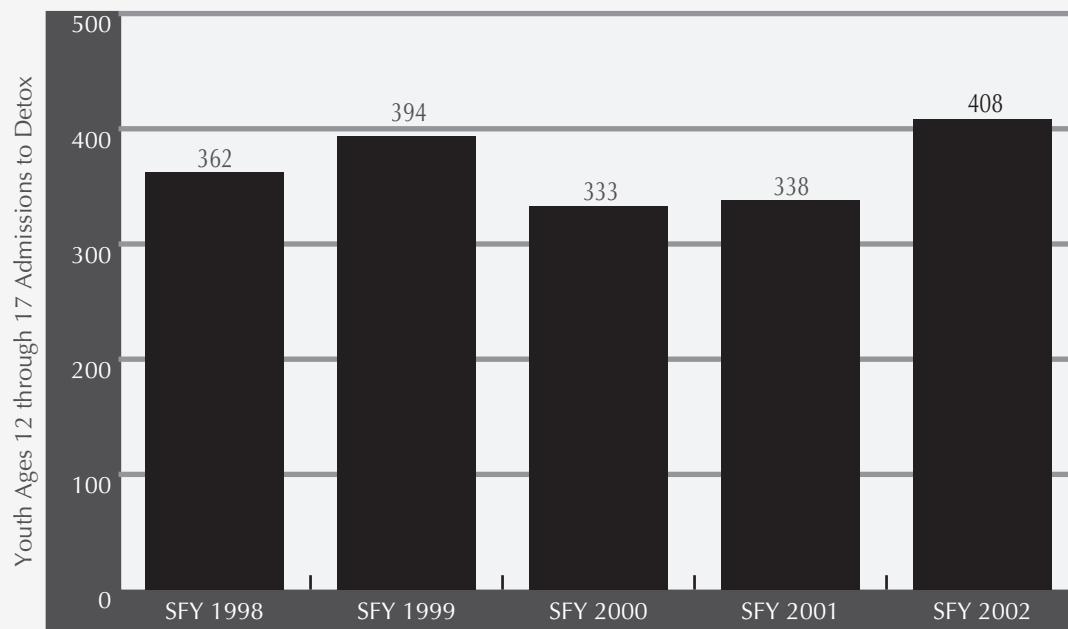
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

While DASA-funded adult treatment admissions for methamphetamine use have peaked, youth admissions continue to rise, from 167 in SFY 1997 to 627 in SFY 2002. Youth are far less likely to inject methamphetamine than adults.

Note: Data excludes detoxification and transitional housing, private-pay, and Department of Corrections admissions; includes total unduplicated admissions within counties.



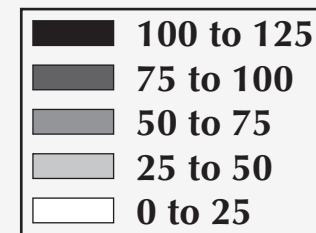
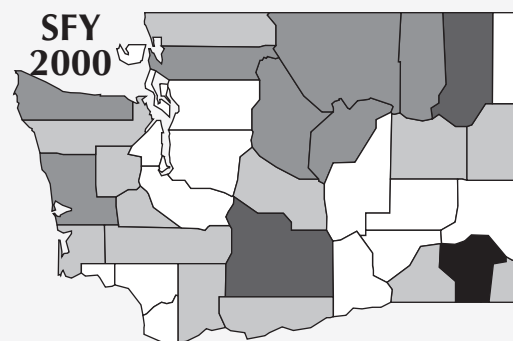
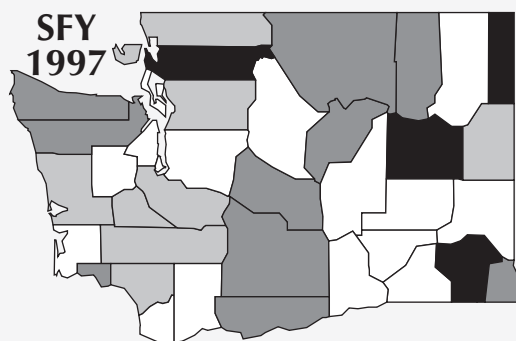
The Number of Youth Receiving DASA-Funded Detoxification Has Remained Relatively Stable Over the Past Five Years.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

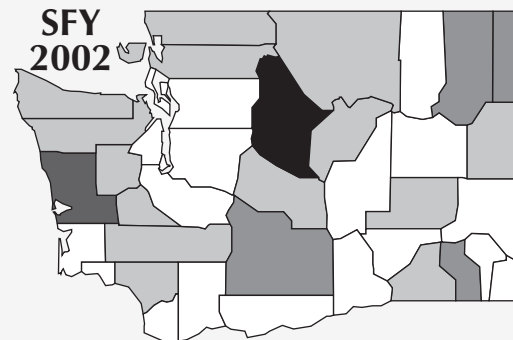
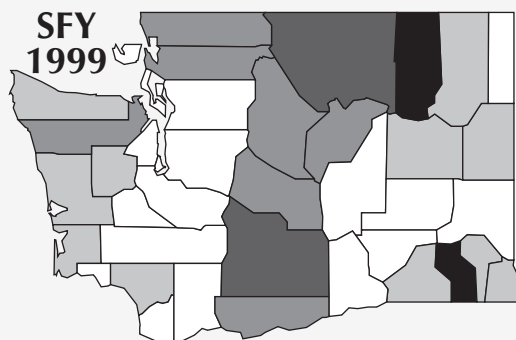
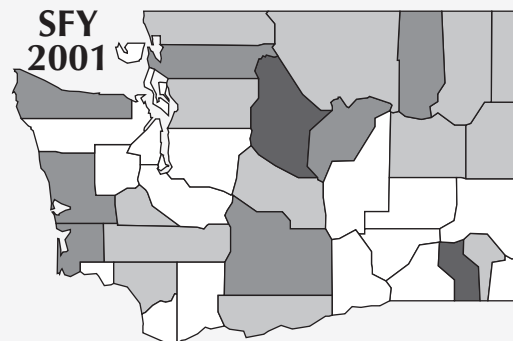
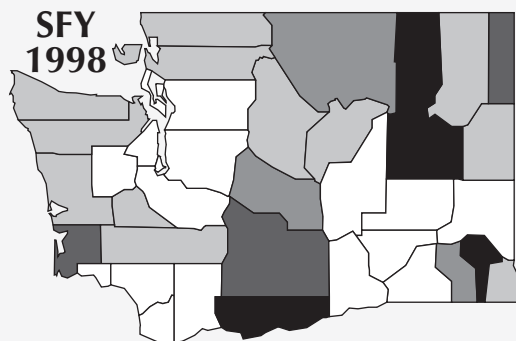
While the overall number of youth undergoing detoxification has remained relatively stable over the past five years, the number of DASA-funded youth detoxifications for alcohol has increased from 59 in SFY 1998 to 135 in SFY 2002, representing a 129% increase. Detoxification from alcohol can be particularly dangerous, and requires close supervision. Detoxification is often a necessary precursor to chemical dependency treatment.

Washington State Youth Treatment Admissions for Alcohol Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service





Washington State Youth Treatment Admissions * Primary Drug = Alcohol

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	3	18.8	3	18.6	1	6.2	3	18.3	2	12.0	5	30.1
Asotin	12	59.2	9	43.3	10	48.5	6	29.2	2	9.7	0	0.0
Benton	27	19.8	23	16.7	16	11.4	27	19.0	14	9.7	18	12.2
Chelan	12	18.2	23	34.6	48	71.7	45	67.6	64	95.4	77	113.9
Clallam	42	66.8	31	48.9	32	49.7	45	69.7	34	52.5	24	37.0
Clark	43	13.6	44	13.4	46	13.6	40	11.6	35	9.9	39	10.7
Columbia	7	154.6	3	66.9	6	140.4	5	123.0	4	97.6	3	73.2
Cowlitz	31	34.2	16	17.5	24	25.9	23	24.7	26	27.7	29	30.7
Douglas	19	60.8	9	28.1	22	67.6	18	55.2	18	54.9	14	42.3
Ferry	4	56.1	13	184.6	9	123.8	4	55.1	5	68.5	0	0.0
Franklin	7	14.8	11	23.0	6	12.4	12	24.3	7	13.9	1	1.9
Garfield	5	222.0	4	175.5	1	41.9	5	208.6	1	41.7	0	0.0
Grant	16	22.7	10	13.8	11	15.0	8	10.7	5	6.6	11	14.4
Grays Harbor	23	33.7	19	28.1	33	49.0	45	67.0	48	70.1	52	76.0
Island	14	20.3	8	11.5	7	9.9	16	22.4	18	24.9	18	24.6
Jefferson	13	51.8	8	31.4	17	66.2	9	34.7	2	7.7	10	37.6
King	359	21.4	357	21.0	373	21.7	342	19.7	295	16.8	298	16.8
Kitsap	49	21.5	51	22.2	43	18.7	12	5.2	23	9.9	35	14.9
Kittitas	17	52.6	24	74.3	21	60.8	15	45.0	15	44.1	9	25.9
Klickitat	12	64.4	20	108.4	12	63.9	6	31.3	7	36.3	1	5.2
Lewis	26	38.6	31	45.6	17	24.8	32	46.6	25	36.0	32	45.6
Lincoln	19	192.2	14	138.9	4	39.4	5	49.1	5	49.0	1	9.8
Mason	9	19.0	8	16.7	11	22.7	15	30.4	3	6.0	14	28.1
Okanogan	26	64.6	26	65.9	39	98.9	28	70.8	14	35.3	18	45.2
Pacific	5	24.0	17	81.2	9	42.9	6	28.6	13	61.9	5	23.8
Pend Oreille	12	101.6	11	92.8		0.0	1	8.5	4	33.9	6	50.8
Pierce	192	28.7	132	19.4	129	18.7	125	17.8	102	14.3	84	11.6
San Juan	5	38.7	4	30.2	1	7.1	2	14.2	2	13.9	5	34.2
Skagit	136	139.0	51	51.1	76	74.5	74	71.9	52	50.0	37	35.2
Skamania	2	20.9	1	10.5	1	10.4	3	30.4	0	0.0	2	20.2
Snohomish	149	26.7	109	18.9	96	16.2	109	18.0	159	25.7	99	15.8
Spokane	154	37.6	108	26.1	127	30.5	119	28.5	137	32.4	128	30.1
Stevens	4	10.6	13	34.1	13	33.5	38	94.8	26	64.5	23	56.9
Thurston	71	35.7	83	41.0	51	24.8	52	25.1	81	38.5	74	34.9
Wahkiakum	2	51.5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	12	21.7	7	12.6	15	27.2	15	27.2	11	19.9	15	27.1
Whatcom	73	46.4	69	43.1	92	56.0	82	49.2	62	36.3	77	44.7
Whitman	3	7.4	7	17.0	7	17.0	2	4.9	3	7.4	2	4.9
Yakima	132	59.0	183	82.1	223	99.7	186	83.6	157	69.9	128	56.9
Total	1,747	30.8	1,560	27.1	1,649	28.3	1,580	26.8	1,481	24.8	1,394.0	23.1

* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Marijuana Per 100,000 in Population



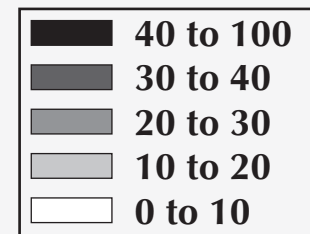
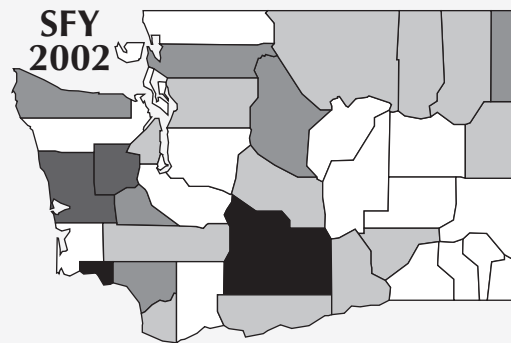
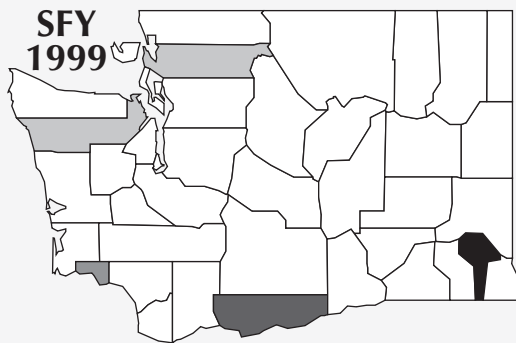
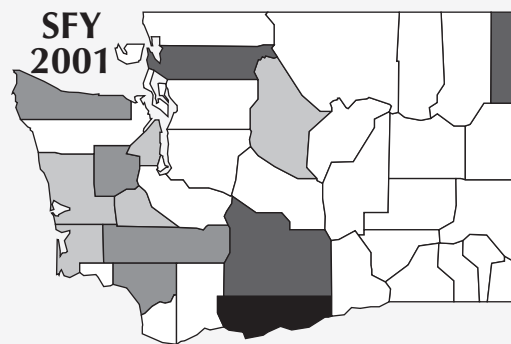
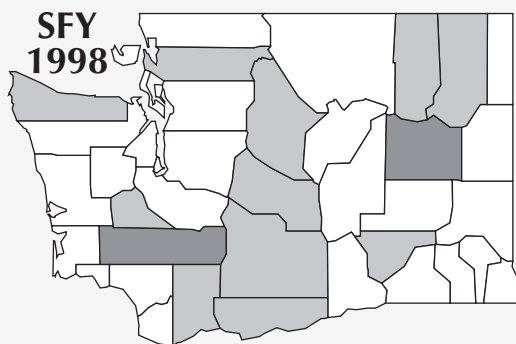
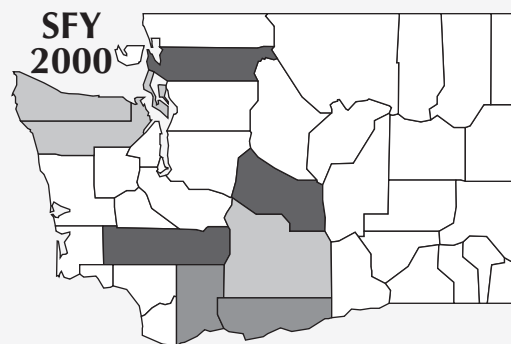
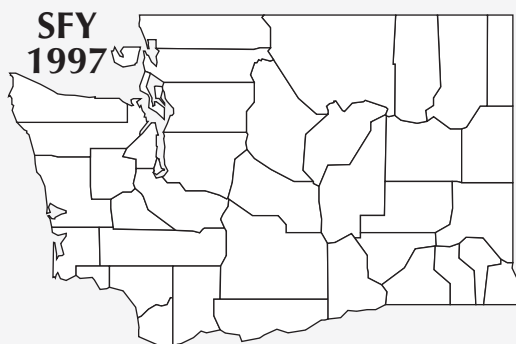


Washington State Youth Treatment Admissions * Primary Drug = Marijuana

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	7	43.8	2	12.4	2	12.4	7	42.6	4	24.1	0	0
Asotin	23	113.5	14	67.4	21	101.9	18	87.6	6	29	10	48.3
Benton	79	57.9	85	61.6	50	35.6	79	55.4	83	57.3	96	65
Chelan	24	36.4	35	52.7	68	101.6	72	108.1	70	104.3	76	112.4
Clallam	86	136.7	41	64.6	81	125.8	112	173.6	85	131.2	75	115.6
Clark	99	31.2	132	40.3	162	48	157	45.5	193	54.7	139	38.2
Columbia	5	110.4	5	111.5	1	23.4	2	49.2	1	24.4	1	24.4
Cowlitz	58	63.9	41	44.8	38	41	80	86.1	85	90.5	65	68.9
Douglas	23	73.6	12	37.4	21	64.6	11	33.7	30	91.5	9	27.2
Ferry	5	70.2	7	99.4	1	13.8	1	13.8	3	41.1	2	27.4
Franklin	20	42.4	17	35.6	15	31.1	20	40.5	11	21.8	25	48.7
Garfield	1	44.4	2	87.8	3	125.6	1	41.7	1	41.7	0	0
Grant	25	35.5	16	22.1	14	19	15	20.1	18	23.7	28	36.6
Grays Harbor	39	57.2	54	79.9	129	191.5	97	144.4	144	210.2	108	157.9
Island	13	18.8	52	74.7	44	62.4	45	62.9	31	42.8	47	64.3
Jefferson	17	67.7	35	137.5	37	144.2	39	150.3	28	107.3	35	131.6
King	868	51.7	972	57.1	1012	58.8	1200	69.1	1016	57.8	978	55.1
Kitsap	135	59.2	157	68.3	120	52.3	83	35.8	118	50.6	153	65.2
Kittitas	24	74.2	29	89.8	36	104.2	42	125.9	19	55.9	30	86.2
Klickitat	24	128.8	38	205.9	22	117.1	25	130.5	16	82.9	12	62.2
Lewis	59	87.6	68	100.1	50	72.9	90	131.2	102	146.8	108	153.8
Lincoln	10	101.2	9	89.3	8	78.9	5	49.1	2	19.6	5	49
Mason	31	65.6	31	64.7	32	66	51	103.2	44	88.7	62	124.5
Okanogan	16	39.7	8	20.3	15	38	19	48	28	70.5	19	47.7
Pacific	16	76.9	20	95.5	16	76.3	4	19.1	19	90.5	17	81
Pend Oreille	5	42.3	5	42.2	0	0	7	59.7	7	59.3	17	144.1
Pierce	378	56.6	420	61.7	306	44.2	376	53.7	310	43.5	374	51.6
San Juan	8	62	10	75.5	6	42.8	3	21.3	9	62.5	12	82.2
Skagit	142	145.1	113	113.2	120	117.6	153	148.6	138	132.6	71	67.6
Skamania	3	31.4	4	41.8	6	62.6	7	70.9	6	60.6	9	90.9
Snohomish	268	48.1	293	50.9	300	50.7	388	64	349	56.4	338	53.8
Spokane	369	90.1	295	71.3	365	87.6	364	87.1	382	90.4	401	94.2
Stevens	31	82.4	22	57.7	35	90.3	45	112.3	60	148.9	47	116.3
Thurston	136	68.3	181	89.4	181	88.1	160	77.2	193	91.8	147	69.2
Wahkiakum	3	77.3	2	51.5	2	51.6	1	26.2	0	0	4	105.3
Walla Walla	21	38	29	52.2	32	58.1	35	63.4	42	76.1	35	63.2
Whatcom	124	78.8	125	78	132	80.3	155	92.9	137	80.3	168	97.6
Whitman	12	29.4	11	26.8	9	21.8	3	7.4	13	32.3	16	39.4
Yakima	394	176	447	200.6	568	254	526	236.3	480	213.8	473	210.2
Total	3,601	63.6	3,839	66.8	4,060	69.6	4,498	76.3	4,283	71.7	4,212	69.7

* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service

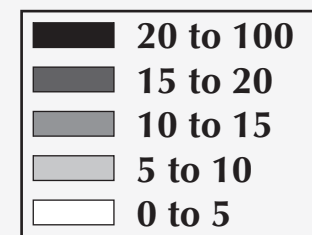
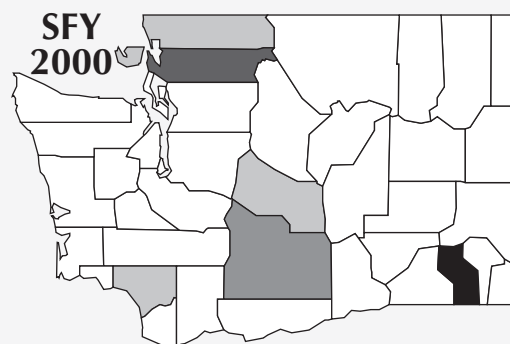
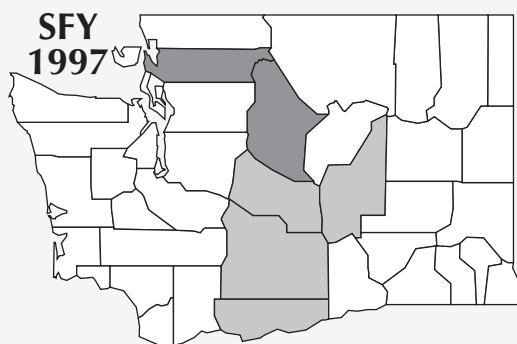


Washington State Youth Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0	0	0	0	0	0	0	0	0	0	0
Asotin	1	4.9	0	0	1	4.9	1	4.9	0	0	2	9.7
Benton	8	5.9	10	7.3	4	2.8	3	2.1	13	9	17	11.5
Chelan	3	4.5	12	18.1	4	6	4	6	15	22.4	14	20.7
Clallam	6	9.5	11	17.3	6	9.3	10	15.5	17	26.2	15	23.1
Clark	9	2.8	26	7.9	24	7.1	33	9.6	31	8.8	48	13.2
Columbia	0	0	0	0	0	0	0	0	0	0	0	0
Cowlitz	5	5.5	8	8.7	5	5.4	9	9.7	26	27.7	27	28.6
Douglas	3	9.6	3	9.4	1	3.1	0	0	3	9.1	2	6
Ferry	0	0	1	14.2	0	0	0	0	0	0	1	13.7
Franklin	1	2.1	5	10.5	0	0	2	4.1	3	6	6	11.7
Garfield	0	0	0	0	1	41.9	0	0	0	0	0	0
Grant	0	0	4	5.5	0	0	0	0	1	1.3	5	6.5
Grays Harbor	3	4.4	7	10.4	5	7.4	6	8.9	12	17.5	23	33.6
Island	2	2.9	7	10.1	8	11.3	11	15.4	3	4.1	4	5.5
Jefferson	0	0	1	3.9	3	11.7	5	19.3	2	7.7	4	15
King	43	2.6	41	2.4	39	2.3	68	3.9	70	4	75	4.2
Kitsap	12	5.3	17	7.4	8	3.5	26	11.2	31	13.3	31	13.2
Kittitas	1	3.1	6	18.6	4	11.6	11	33	5	14.7	5	14.4
Klickitat	0	0	5	27.1	0	0	5	26.1	11	57	2	10.4
Lewis	7	10.4	26	38.3	8	11.7	26	37.9	21	30.2	14	19.9
Lincoln	0	0	4	39.7	0	0	1	9.8	0	0	0	0
Mason	0	0	6	12.5	2	4.1	7	14.2	14	28.2	15	30.1
Okanogan	0	0	2	5.1	1	2.5	0	0	2	5	4	10.1
Pacific	0	0	0	0	1	4.8	3	14.3	3	14.3	2	9.5
Pend Oreille	0	0	1	8.4	0	0	1	8.5	4	33.9	3	25.4
Pierce	42	6.3	45	6.6	40	5.8	54	7.7	64	9	40	5.5
San Juan	0	0	0	0	0	0	0	0	3	20.8	0	0
Skagit	17	17.4	24	24	19	18.6	34	33	42	40.3	23	21.9
Skamania	0	0	3	31.4	1	10.4	1	10.1	0	0	0	0
Snohomish	25	4.5	36	6.2	20	3.4	27	4.5	38	6.1	65	10.4
Spokane	25	6.1	38	9.2	15	3.6	40	9.6	42	9.9	51	12
Stevens	0	0	4	10.5	0	0	1	2.5	3	7.4	6	14.9
Thurston	19	9.5	28	13.8	17	8.3	11	5.3	40	19	45	21.2
Wahkiakum	0	0	0	0	1	25.8	0	0	0	0	2	52.6
Walla Walla	2	3.6	5	9	3	5.4	2	3.6	3	5.4	3	5.4
Whatcom	0	0	7	4.4	8	4.9	17	10.2	14	8.2	17	9.9
Whitman	0	0	0	0	1	2.4	1	2.5	1	2.5	0	0
Yakima	14	6.3	46	20.6	20	8.9	34	15.3	80	35.6	102	45.3
Total	248	4.4	439	7.6	270	4.6	454	7.7	617	10.3	673	11.1

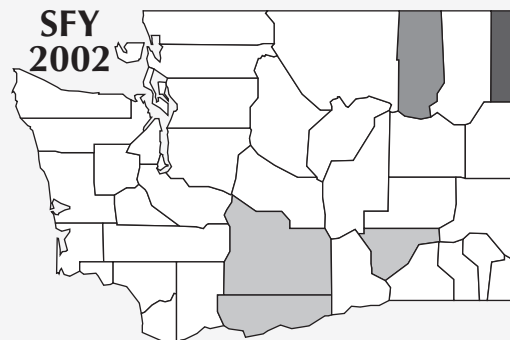
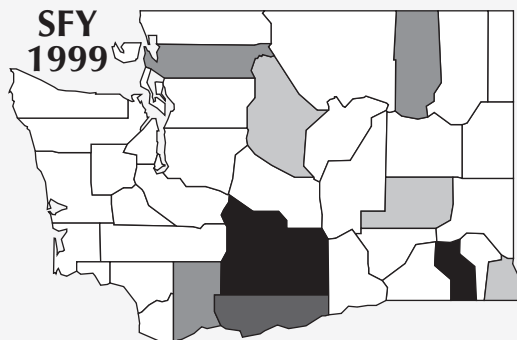
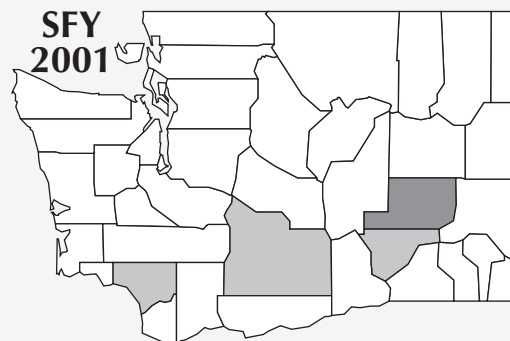
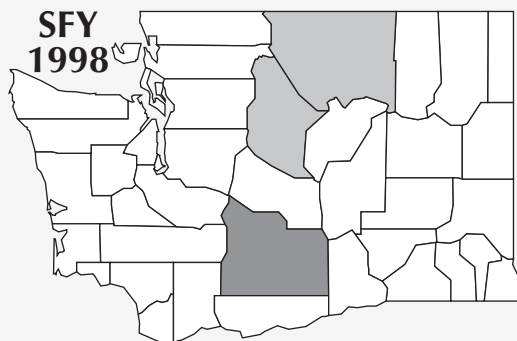
* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Cocaine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service





Washington State Youth Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0	0	0	1	6.2	0	0	2	12	0	0
Asotin	0	0	0	0	2	9.7	0	0	0	0	1	4.8
Benton	1	0.7	1	0.7	1	0.7	2	1.4	4	2.8	1	0.7
Chelan	9	13.6	5	7.5	4	6	0	0	3	4.5	2	3
Clallam	1	1.6	1	1.6	0	0	0	0	0	0	0	0
Clark	2	0.6	3	0.9	2	0.6	3	0.9	2	0.6	3	0.8
Columbia	0	0	0	0	1	23.4	1	24.6	0	0	0	0
Cowlitz	2	2.2	1	1.1	1	1.1	7	7.5	7	7.5	3	3.2
Douglas	1	3.2	0	0	0	0	0	0	1	3	0	0
Ferry	0	0	0	0	1	13.8	0	0	0	0	1	13.7
Franklin	1	2.1	1	2.1	1	2.1	0	0	4	7.9	5	9.7
Garfield	0	0	0	0	0	0	0	0	0	0	0	0
Grant	5	7.1	2	2.8	2	2.7	2	2.7	1	1.3	2	2.6
Grays Harbor	2	2.9	1	1.5	1	1.5	0	0	2	2.9	2	2.9
Island	0	0	0	0	3	4.3	0	0	0	0	2	2.7
Jefferson	0	0	1	3.9	0	0	0	0	1	3.8	0	0
King	26	1.5	24	1.4	46	2.7	35	2	33	1.9	13	0.7
Kitsap	1	0.4	1	0.4	4	1.7	2	0.9	0	0	1	0.4
Kittitas	2	6.2	0	0	1	2.9	3	9	0	0	0	0
Klickitat	1	5.4	0	0	3	16	0	0	0	0	1	5.2
Lewis	1	1.5	3	4.4	0	0	2	2.9	1	1.4	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0
Mason	0	0	1	2.1	2	4.1	2	4	1	2	0	0
Okanogan	0	0	2	5.1	1	2.5	1	2.5	1	2.5	0	0
Pacific	0	0	0	0	1	4.8	1	4.8	0	0	0	0
Pend Oreille	0	0	0	0	0	0	0	0	0	0	2	16.9
Pierce	8	1.2	6	0.9	9	1.3	12	1.7	2	0.3	4	0.6
San Juan	0	0	0	0	0	0	1	7.1	0	0	0	0
Skagit	11	11.2	3	3	13	12.7	16	15.5	4	3.8	4	3.8
Skamania	0	0	0	0	1	10.4	0	0	0	0	0	0
Snohomish	17	3.1	10	1.7	20	3.4	20	3.3	5	0.8	22	3.5
Spokane	12	2.9	5	1.2	12	2.9	11	2.6	11	2.6	17	4
Stevens	0	0	0	0	0	0	1	2.5	0	0	1	2.5
Thurston	2	1	5	2.5	3	1.5	6	2.9	1	0.5	5	2.4
Wahkiakum	0	0	0	0	0	0	0	0	0	0	0	0
Walla Walla	1	1.8	0	0	0	0	1	1.8	0	0	1	1.8
Whatcom	5	3.2	6	3.7	5	3	11	6.6	7	4.1	8	4.6
Whitman	1	2.5	1	2.4	0	0	0	0	0	0	1	2.5
Yakima	12	5.4	29	13	58	25.9	30	13.5	21	9.4	21	9.3
Total	124	2.2	112	1.9	199	3.4	170	2.9	114	1.9	123	2

* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Heroin Per 100,000 in Population



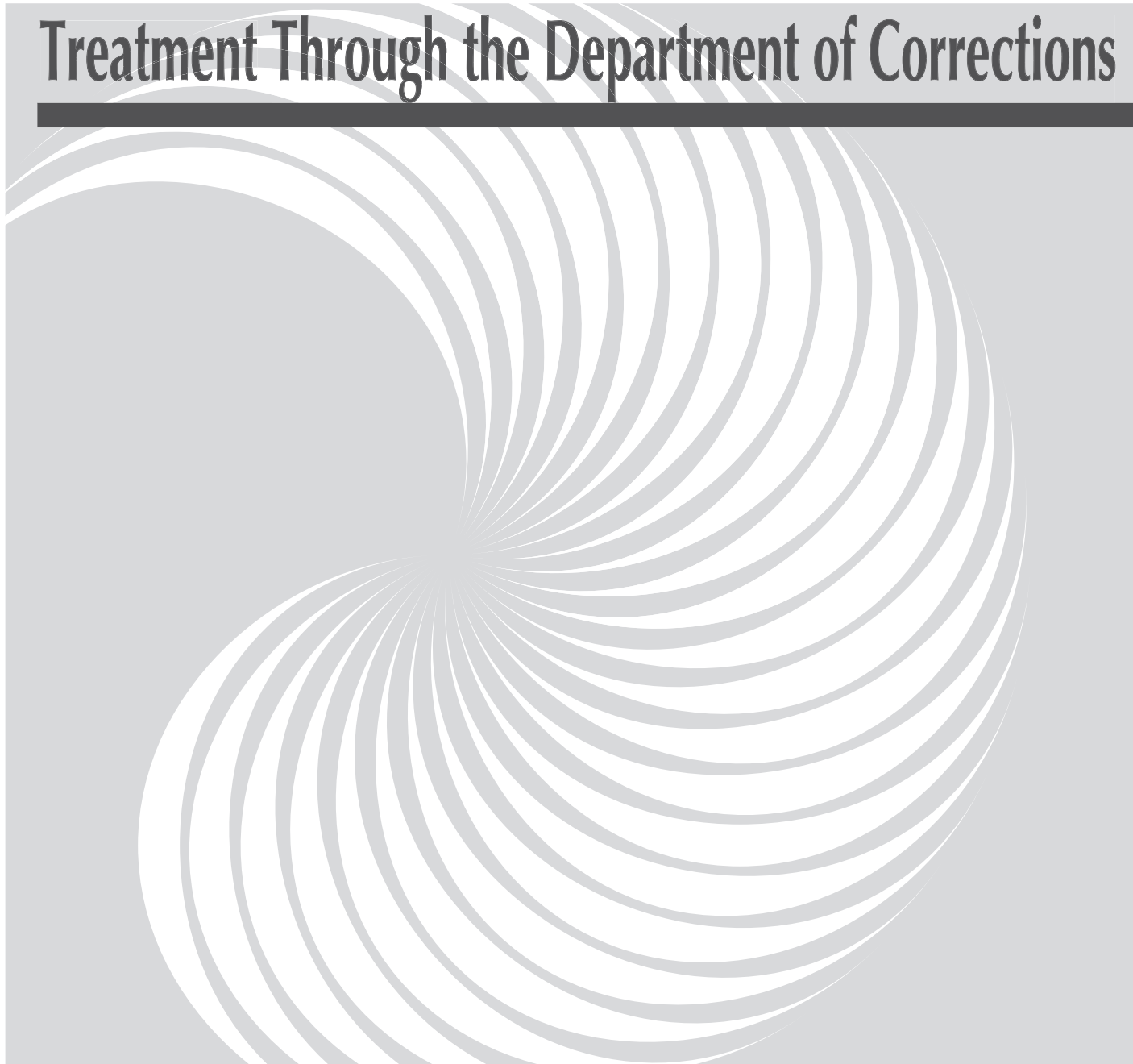


Washington State Youth Treatment Admissions* Primary Drug = Heroin

County Name	SFY 1997		SFY 1998		SFY 1999		SFY 2000		SFY 2001		SFY 2002	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0	1	6.2	0	0	0	0	0	0	0	0
Asotin	0	0	0	0	0	0	0	0	0	0	1	4.8
Benton	1	0.7	0	0	1	0.7	0	0	1	0.7	2	1.4
Chelan	0	0	0	0	1	1.5	0	0	1	1.5	1	1.5
Clallam	1	1.6	0	0	1	1.6	0	0	0	0	0	0
Clark	4	1.3	3	0.9	4	1.2	0	0	1	0.3	0	0
Columbia	0	0	0	0	0	0	0	0	0	0	0	0
Cowlitz	2	2.2	4	4.4	3	3.2	12	12.9	10	10.6	3	3.2
Douglas	0	0	0	0	0	0	0	0	0	0	0	0
Ferry	0	0	0	0	0	0	0	0	0	0	0	0
Franklin	2	4.2	0	0	0	0	0	0	0	0	0	0
Garfield	0	0	0	0	0	0	0	0	0	0	0	0
Grant	0	0	0	0	0	0	0	0	1	1.3	0	0
Grays Harbor	0	0	0	0	1	1.5	0	0	0	0	0	0
Island	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	0	0	0	0	0	0	0	0	0	0	0
King	16	1	23	1.4	21	1.2	14	0.8	15	0.9	6	0.3
Kitsap	0	0	0	0	1	0.4	3	1.3	0	0	4	1.7
Kittitas	0	0	0	0	0	0	0	0	0	0	0	0
Klickitat	0	0	1	5.4	0	0	1	5.2	0	0	0	0
Lewis	2	3	1	1.5	0	0	3	4.4	1	1.4	1	1.4
Lincoln	1	10.1	1	9.9	0	0	0	0	0	0	0	0
Mason	2	4.2	0	0	0	0	0	0	0	0	0	0
Okanogan	0	0	0	0	0	0	0	0	0	0	0	0
Pacific	0	0	0	0	0	0	0	0	0	0	0	0
Pend Oreille	0	0	0	0	0	0	0	0	0	0	0	0
Pierce	4	0.6	4	0.6	0	0	2	0.3	1	0.1	4	0.6
San Juan	0	0	1	7.6	0	0	0	0	0	0	0	0
Skagit	9	9.2	6	6	8	7.8	4	3.9	1	1	2	1.9
Skamania	0	0	0	0	0	0	0	0	0	0	0	0
Snohomish	0	0	6	1	3	0.5	4	0.7	4	0.6	0	0
Spokane	3	0.7	1	0.2	3	0.7	0	0	1	0.2	4	0.9
Stevens	0	0	0	0	0	0	0	0	0	0	1	2.5
Thurston	3	1.5	7	3.5	7	3.4	6	2.9	2	1	2	0.9
Wahkiakum	0	0	0	0	1	25.8	1	26.2	0	0	0	0
Walla Walla	0	0	0	0	0	0	1	1.8	0	0	0	0
Whatcom	1	0.6	1	0.6	3	1.8	4	2.4	5	2.9	3	1.7
Whitman	0	0	0	0	0	0	0	0	0	0	0	0
Yakima	4	1.8	0	0	6	2.7	15	6.7	15	6.7	7	3.1
Total	55	1	60	1	64	1.1	70	1.2	59	1	41	0.7

* Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions - counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Through the Department of Corrections





The Washington State Department of Corrections Responds to the Need for Chemical Dependency Treatment

Over the past decade, the need for quality chemical dependency treatment among inmates in the custody of the Washington State Department of Corrections (DOC) has become increasingly apparent. More than one in five inmates in DOC custody – in prisons, pre-release facilities, and work release – were convicted of drug offenses, making drug crimes the single largest category of offenses. Between 60-80% of inmates are estimated to be in need of treatment.

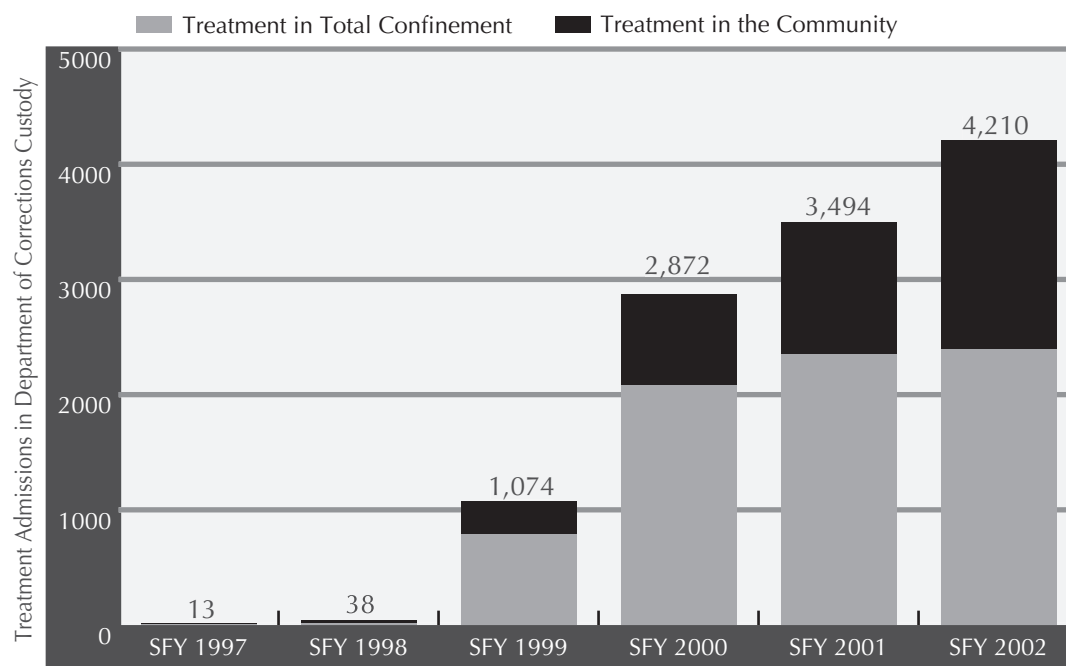
Responding to this need, DOC provides a multi-phased continuum of care which includes: screening; diagnostic assessment; intensive primary treatment; coordinated transition and case management; outpatient treatment; and referral to community-based treatment. All DOC treatment programs are certified by the Division of Alcohol and Substance Abuse, and employ offender-specific, research-based best practices and utilize federal Treatment Improvement Protocol (TIP) guidelines. The goal of these programs is to reduce reoffense, enhance the safety of communities, and prepare offenders for more productive lives once they are released.

DOC provides two primary treatment modalities:

- **Residential Therapeutic Community (TC)** – TC is a progressive, phased program of care, 9-12 months in length. Through TC, patients are provided a separate living area and a highly structured treatment environment, including traditional chemical dependency treatment coupled with emphasis upon “right living”, work, education, community, and personal accountability. Services are delivered by a multi-disciplinary team. Development and demonstration of specific behaviors are required prior to transition to further program phases.
- **Intensive Outpatient (IOP)** – Within DOC, IOP is a 72-hour, highly structured intervention delivered in a “day treatment” environment. Available in total and partial confinement as well as in the community, IOP is offered in varying lengths of stay, ranging from five to 12 weeks, in order to conform to the sentence structure and meet the needs of offenders in different institutions.

Following completion of any primary level of treatment, offenders are admitted to and complete outpatient treatment, which may continue for up to 12 months. A minimum of three months of outpatient treatment will take place in the community.

Washington State Has Made a Major Commitment to Providing Chemical Dependency Treatment to Offenders in Total Confinement and in Community Custody.



Source: Washington State Department of Corrections, July 2003.

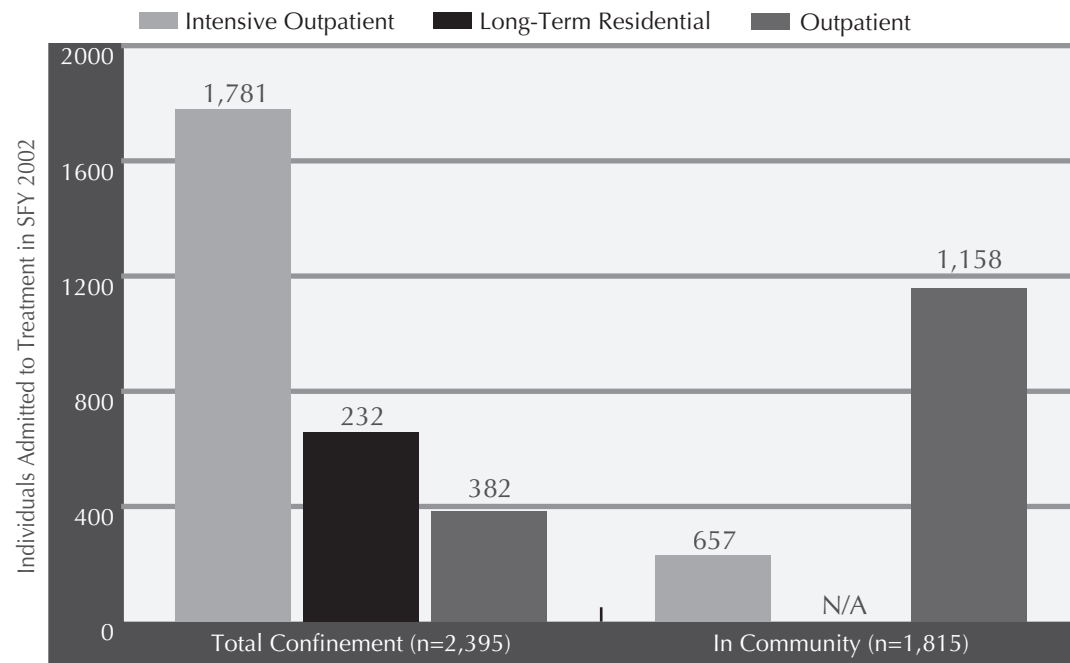
This graph indicates the depth of commitment Washington State has made in recent years toward the provision of alcohol and drug treatment services to offenders in the state correctional system. Especially noteworthy is the expansion of services to offenders in community custody.

Consistent with best practices, offenders are admitted to treatment as close to release from total confinement as possible. Based on an offender's clinical progress while in confinement, outpatient treatment may continue as needed, with a minimum of three months of treatment occurring after release. The treatment completion rate among offenders in Department of Corrections custody in SFY 2002 was 75%.¹



The Majority of Individuals Admitted to Chemical Dependency Treatment in the State Correctional System Receive Intensive Outpatient Treatment

Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2002



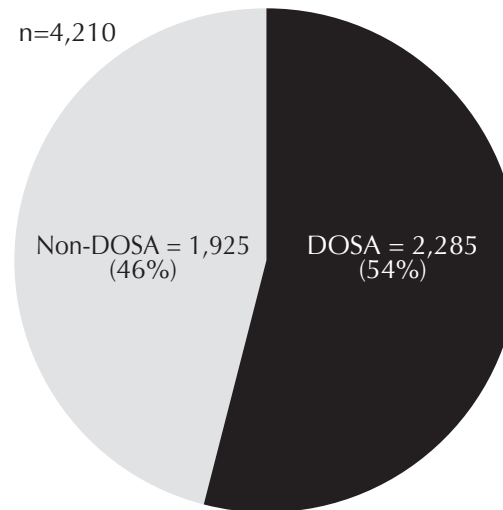
Source: Washington State Department of Corrections, July 2003.

The Washington State Department of Corrections offers three levels of chemical dependency treatment to offenders in custody who are assessed as in need. Long-term residential treatment is delivered in therapeutic communities, providing a highly structured living and treatment environment. Intensive outpatient treatment, provided both in correctional facilities and in the community, provides a 72-hour, highly structured intervention over a period of 5-12 weeks. Outpatient treatment, also provided in both correctional facilities and in the community, follows completion of other primary levels of treatment. It may continue for up to 12 months, with a minimum of three months provided in the community.

The Majority of Individuals Receiving Chemical Dependency Treatment in the State Correctional System are Sentenced Under the Drug Offender Sentencing Alternative (DOSA).



Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2002



Source: Washington State Department of Corrections, July 2003.

The Drug Offender Sentencing Alternative (DOSA) provides judges with the option of ensuring those offenders who: A) pose a moderate to high risk of reoffense; B) pose a risk to public safety; and C) have had their lives disrupted due to substance abuse problems may receive chemical dependency treatment through the Department of Corrections. To qualify, offenders must have no current or prior sex or violent offenses and must not have used a deadly weapon in the commission of the offense. Additionally, if the offense was a violation of the Uniform Controlled Substance Act, the offense must have involved only a small quantity of illicit drugs.

Under DOSA, the offender serves one half of the mid-point of the standard sentencing range for the offense in total confinement, with the remainder of the term to be served in community custody. During incarceration, offenders undergo a comprehensive substance abuse assessment and receive appropriate treatment services. Services continue when the offender is released into community custody. Failure to meet conditions of the sentence – which can include drug testing and monitoring, and education or employment training – can result in imposition of the balance of the original sentence.

Outcomes: The Benefits of Prevention & Treatment

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Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Mentally Ill
Chemically
Abusing Patients

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction

The Work of the DASA Research and Evaluation Section



The Division of Alcohol and Substance Abuse's (DASA's) Research and Evaluation Section was created to respond to the need to demonstrate the effectiveness of substance abuse prevention and treatment in serving the overall mission of the Department of Social and Health Services (DSHS), "to improve the quality of life for individuals and families in need." Through research and evaluation activities, DASA is able to document the role of alcohol- and drug-related services in enhancing client self-sufficiency; protecting vulnerable adults, children, and families; and assuring public safety and helping to build strong, healthy communities. Research also aids in the development of "best practices" that can be utilized by chemical dependency treatment providers in improving the quality of care, and provides the scientific basis for the development of sound public policy.

DASA's productivity in research and evaluation is due, at least in part, to the strong partnership it has developed with the research community over the last decade. This is most evident in the 90-member Research Subcommittee of the Citizens Advisory Council on Alcoholism and Drug Addiction. Members are drawn from research institutions throughout the Northwest. DASA also coordinates a statewide "Bridging the Gaps" workgroup, which seeks to forge new partnerships among researchers, prevention and treatment providers, and policymakers.

Current Research Efforts

Some of the results of the outcomes research conducted under the auspices of DASA on the benefits of prevention and treatment are displayed on the following pages. Below is a partial list of research projects currently underway:

- Arrestee Drug Abuse Monitoring Project
- Evaluation of the Washington State Drug-Free Workplace Program
- Statewide Household Survey to Assess Need for Treatment Among Adults in Washington State
- Treatment Outcomes of Persons with Co-Occurring Mental Health and Substance Abuse Disorders
- Outcomes of Pregnant, Postpartum, and Parenting Women Who Receive Specialized Chemical Dependency Services
- Treatment Outcomes of Parenting Women Who Participate in Specialized and Non-Specialized Long-Term Care
- Analysis of Use, Cost, and Outcomes of Opiate Substitution Treatment Services in Washington and Oregon
- School Outcomes of Youth in Publicly Funded Treatment
- Cost Offsets of Treatment for Supplemental Security Income (SSI) Recipients
- Evaluation of the RUaD (Reduce Underage Drinking) Program

In addition, the Research and Evaluation Section is assisting in development of a web-based client outcome tracking system for use by providers, county coordinators, and state-level managers.

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Profile of Adolescents Served in Publicly Funded Chemical Dependency Programs in Washington State

A profile of adolescents (ages 12 through 17) admitted to publicly funded chemical dependency treatment in Washington State in SFY 2002 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	5,657
<i>Median Age:</i>	16
<i>Gender:</i>	64% male; 36% female
<i>School Attendance:</i>	70% in school (at least part-time); 30% out of school
<i>Primary Drug:</i>	Marijuana - 65%; Alcohol -21%; Stimulants (including Methamphetamine) - 9%
<i>Criminal Justice Involvement:</i>	67% arrested at least once in previous year
<i>Housing Status:</i>	2% homeless*

A 1999 study of adolescents (age 20 and younger) admitted to publicly funded chemical dependency treatment revealed the following profile:

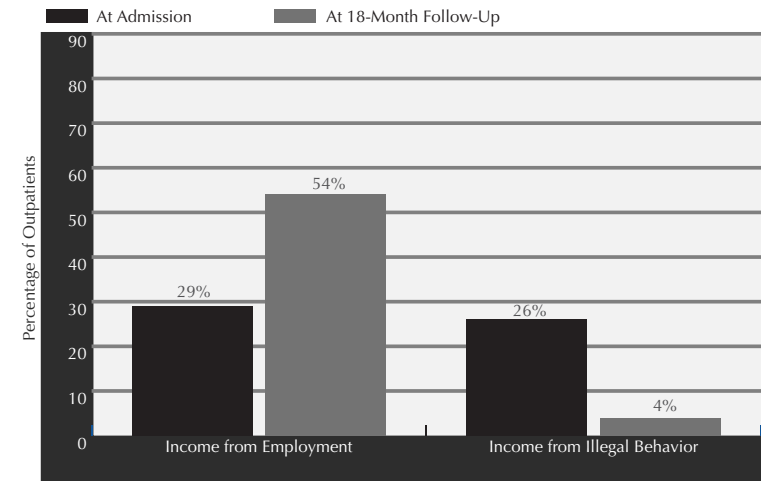
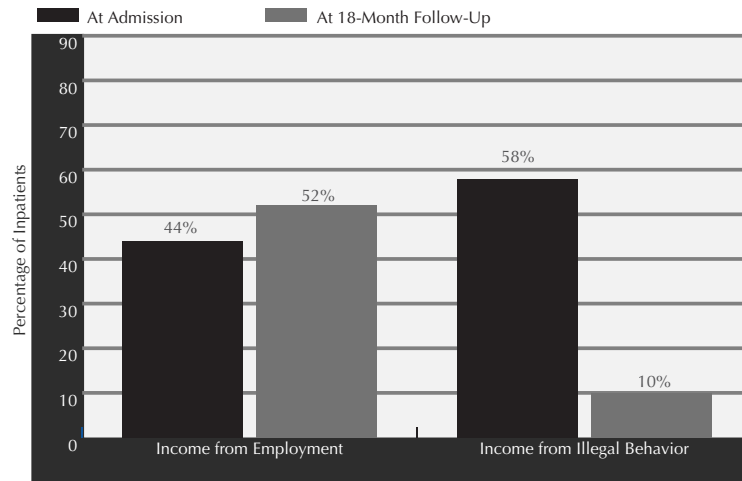
- Between 55-70% of youth admitted to residential treatment had run away from home at least once in their lives.
- Between 23-34% of youth had one or more emergency room visits in the year prior to admission.
- 90% of youth admitted to treatment began using their primary substance of abuse prior to age 16.
- Between 70-90% reported at time of admission that they currently smoke cigarettes.
- Between 23-37% of those admitted to residential treatment had been domestic violence victims.²

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Rodriguez, F., *Profile of Youth Clients Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998*. Olympia, Washington: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

A Greater Number of Adolescents Reported Income Earned from Employment, and Less Income from Illegal Behavior After Treatment.

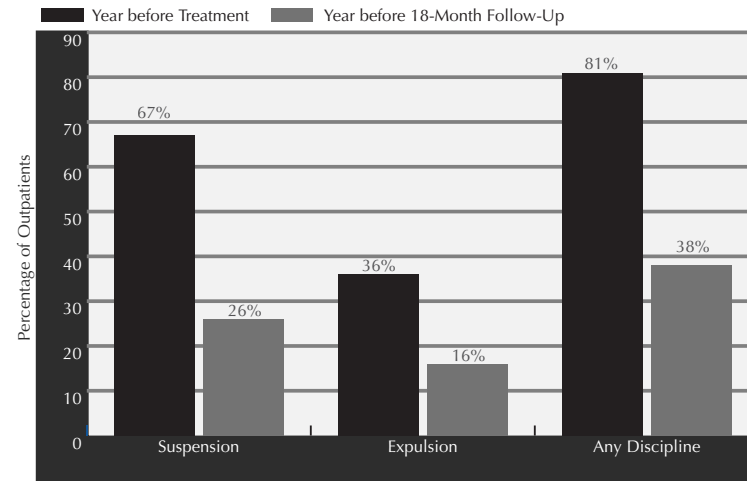
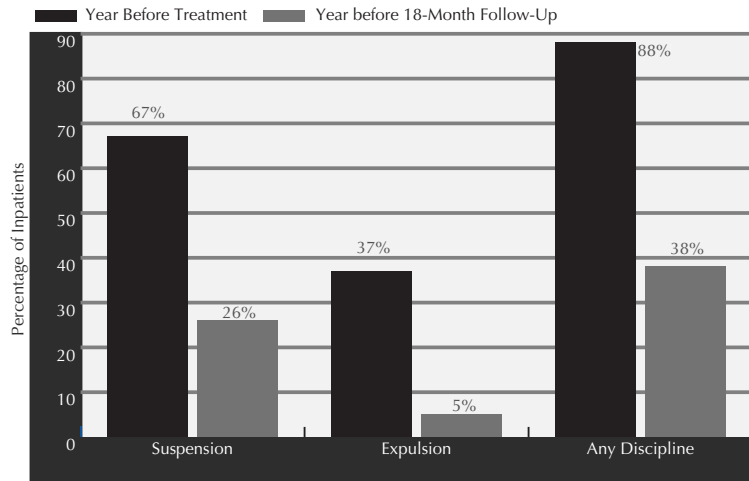


Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

At the time of admission, adolescent inpatients were more likely to report income from illegal behavior than from legitimate employment, while outpatients were almost equally as likely to report income from both sources. At the time of the 18-month follow-up, however, adolescents who had been in both inpatient and outpatient treatment were five times more likely to report income from employment rather than illegal behavior.



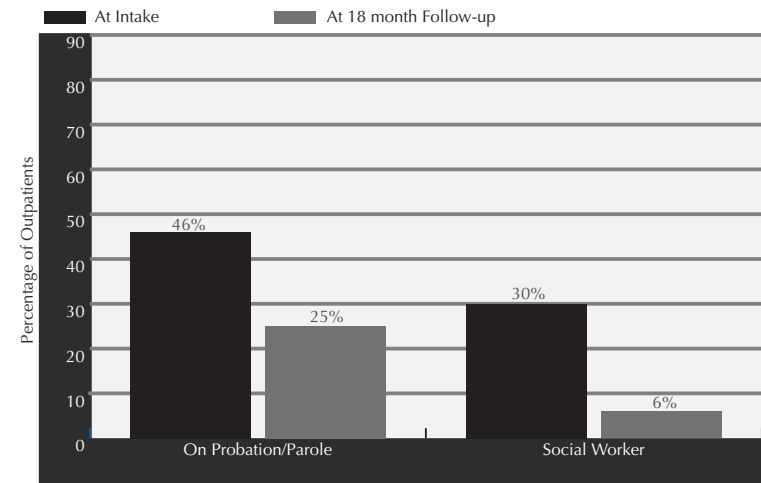
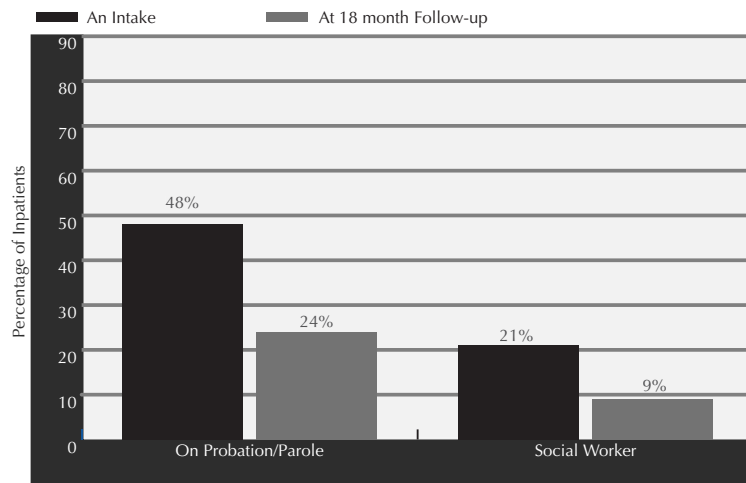
School Discipline Problems for Adolescent Patients Decreased After Treatment.



Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

Not surprisingly, adolescents with substance abuse problems tend to experience behavioral problems when attending school. After substance abuse treatment, however, the number of adolescents reporting any school discipline problems in the preceding year dropped by 50%. An especially encouraging outcome is the substantial reduction in school expulsions for youth receiving either inpatient or outpatient treatment. Additional study results also showed a corresponding improvement in school grades after treatment.

A Lower Percentage of Adolescent Patients were Under Legal Supervision 18 Months After Treatment.



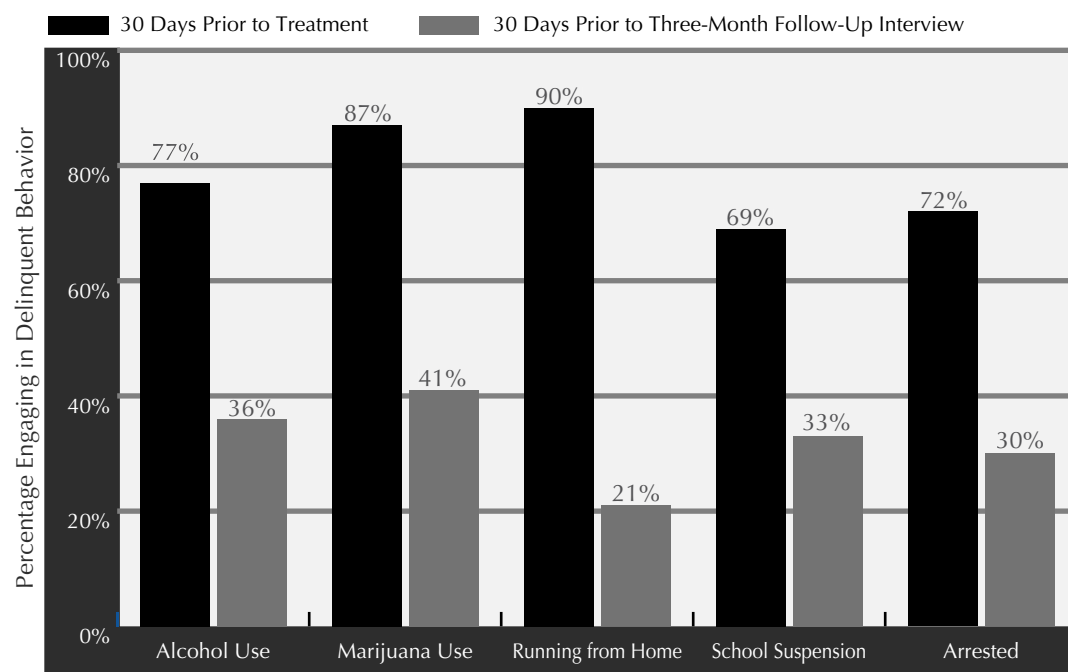
Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

A large proportion of children involved in the juvenile justice system have substance abuse problems and, similarly, a large portion of juveniles in chemical dependency treatment programs are involved in criminal activities. Therefore, it is expected that obtaining substance abuse treatment will have a positive effect on criminal behavior, as well as decreasing or ceasing substance use.

As expected, legal involvement by adolescents decreased considerably after treatment for both inpatients and outpatients. Compared to their status at intake, approximately half as many adolescents were on parole or probation at the time of follow-up. There was a similar reduction in supervision by social workers for inpatients, and only 6% of outpatients were under a social worker's supervision at the 18-month follow-up, compared to 30% at intake.



“Becca” Youth Who Complete Residential Chemical Dependency Treatment Are Much Less Likely to Use Alcohol or Marijuana, Less Likely to Run Away from Home, and Less Likely to Be Suspended from School or Arrested.

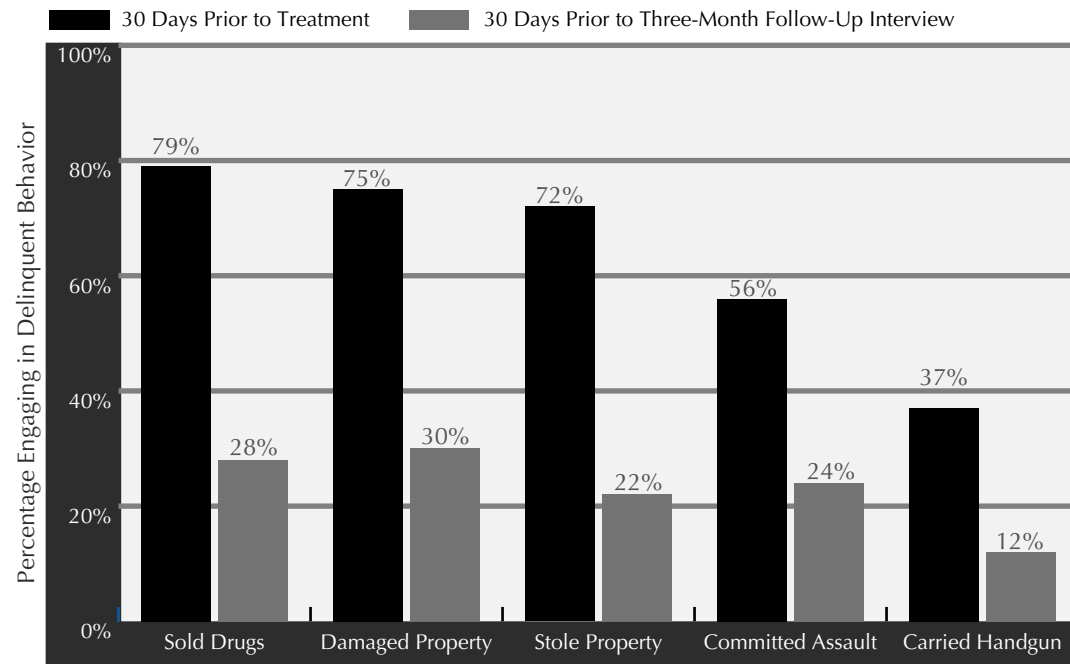


Source: Peterson, P., et al. *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the “Becca” Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

The 1995 At-Risk/Runaway Youth Act created the “Becca” program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent’s control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.

While the needs of Becca Youth are very high, this graph indicates that residential chemical dependency treatment results in significant positive changes in behavior following treatment completion.

Rates of Delinquent Behavior Among “Becca” Youth Decline Substantially Following Completion of Residential Chemical Dependency Treatment.



Source: Peterson, P., et al. *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the “Becca” Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

This graph indicates that Becca youth who receive chemical dependency treatment are much less likely to engage in delinquent behavior following treatment completion. In this 1997 study conducted by the University of Washington, the percentage of Becca youth involved in selling drugs declined by 64.6%; those stealing property dropped by 60.4%; and the percentage of those who committed assault dropped by 57.1%.

The 1995 At-Risk/Runaway Youth Act created the “Becca” program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent’s control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.

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Profile of Pregnant Women Served in Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of pregnant women admitted to publicly funded chemical dependency treatment in Washington State in SFY 2002 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	512
<i>Median Age:</i>	26
<i>Employment Status:</i>	Employed (full- or part-time) – 9%; Unemployed – 91%
<i>Primary Drug:</i>	Stimulants (including Methamphetamine) - 29%; Alcohol – 22%; Marijuana - 21%
<i>Criminal Justice Involvement:</i>	57% arrested at least once in previous year
<i>% with Children in the Home:</i>	43%
<i>Housing Status:</i>	8% homeless*

A 1999 study of pregnant, post-partum, and/or parenting women (PPWs) admitted to publicly funded chemical dependency treatment in Washington State indicated:

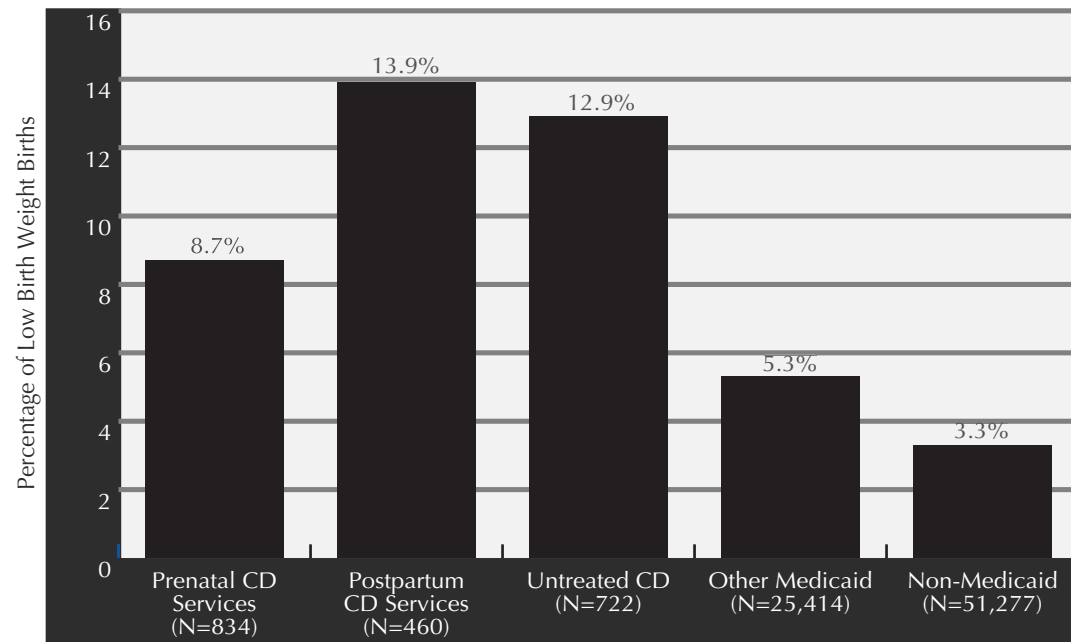
- More than 60% of PPWs admitted to treatment had been victims of domestic violence.
- Over 50% reported public assistance as their primary source of income.
- Between 38-73% had visited an emergency room one or more times in the year prior to treatment admission.
- Over one-quarter reported having received mental health treatment in the year prior to admission.
- Between 26-63% reported having used injection drugs.
- Between 77-92% reported they currently smoke cigarettes.³

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Rodriguez, F., *Profile of Pregnant, Post-Partum, and/or Parenting Women (PPWs) Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998*. Olympia, Washington: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Substance Abusing Women Who Received Chemical Dependency Treatment Prenatally were Less Likely to Have a Low Birth Weight Baby.



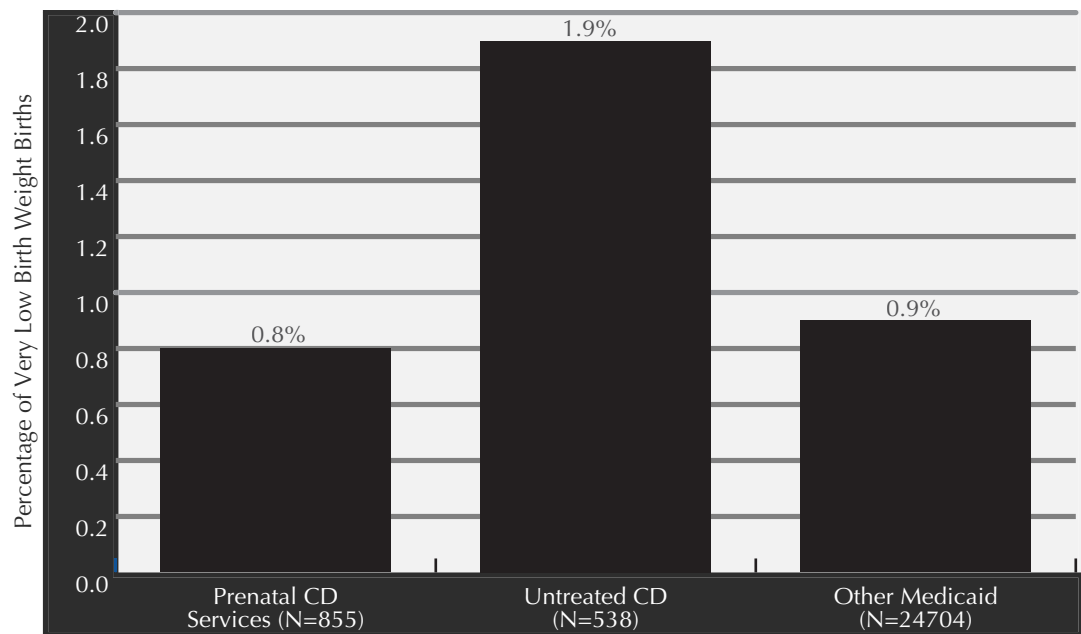
Source: Cawthon, L. "Substance Abuse in Pregnancy." *First Steps Database* 3(1). Washington State Department of Social and Health Services, 1993.

Low birth weight (LBW – newborn infants weighing less than 5.5 pounds, or 2,500 grams) is the risk factor most closely associated with neonatal death, and is associated with a wide range of disorders, including neurodevelopmental conditions, mental retardation, vision and hearing impairments, and other developmental disabilities. Alcohol and other drug abuse is linked to LBW.¹

This graph indicates that chemical dependency treatment during pregnancy is associated with lower rates of LBW among infants born to substance-abusing low income women.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

The Rate of Very Low Birth Weight Babies (<1,500 Grams) Born to Substance-Abusing Women Who Received Prenatal Chemical Dependency Treatment was Less than Half That of Untreated Substance-Abusing Women.



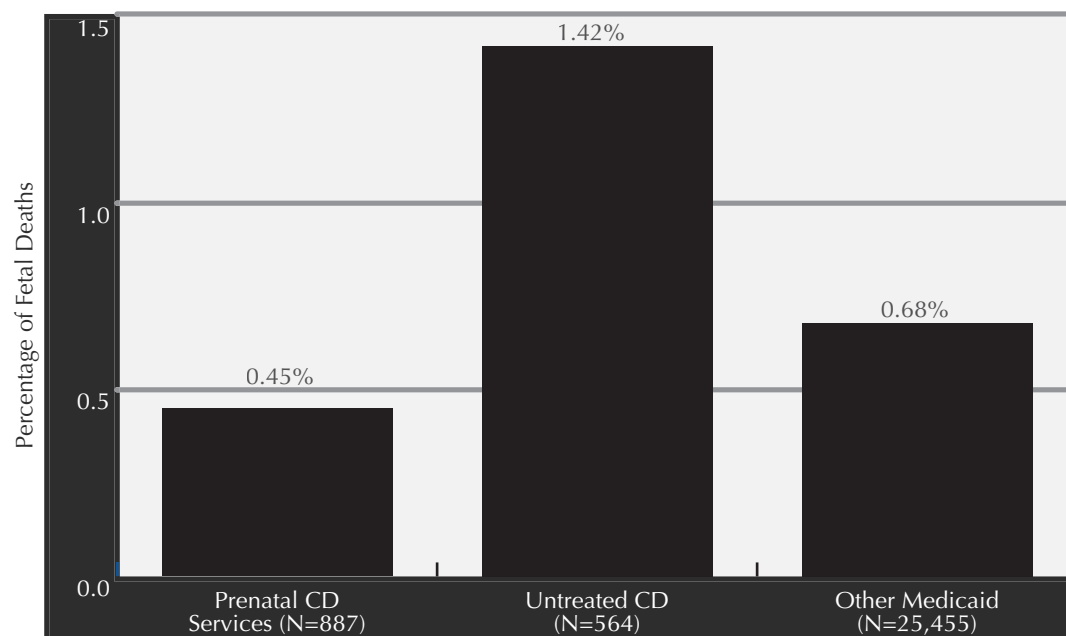
Source: Cawthon, L. "Substance Abuse in Pregnancy." *First Steps Database* 5(1). Washington State Department of Social and Health Services, 1993.

Very low birth weight (VLBW – newborn infants weighing less than 3.3 pounds or 1,500 grams) is closely associated with neonatal death, as well as a wide range of physical, mental, and developmental disorders. VLBW is usually associated with pre-term birth. Cigarette smoking and maternal use of illicit drugs is linked to VLBW.¹

This graph indicates that chemical dependency treatment during pregnancy is associated with lower rates of VLBW among infants born to substance-abusing low income women.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

The Fetal Death Rate for Substance-Abusing Pregnant Women Who Received Chemical Dependency Treatment was One-Third That of Untreated Substance-Abusing Pregnant Women.



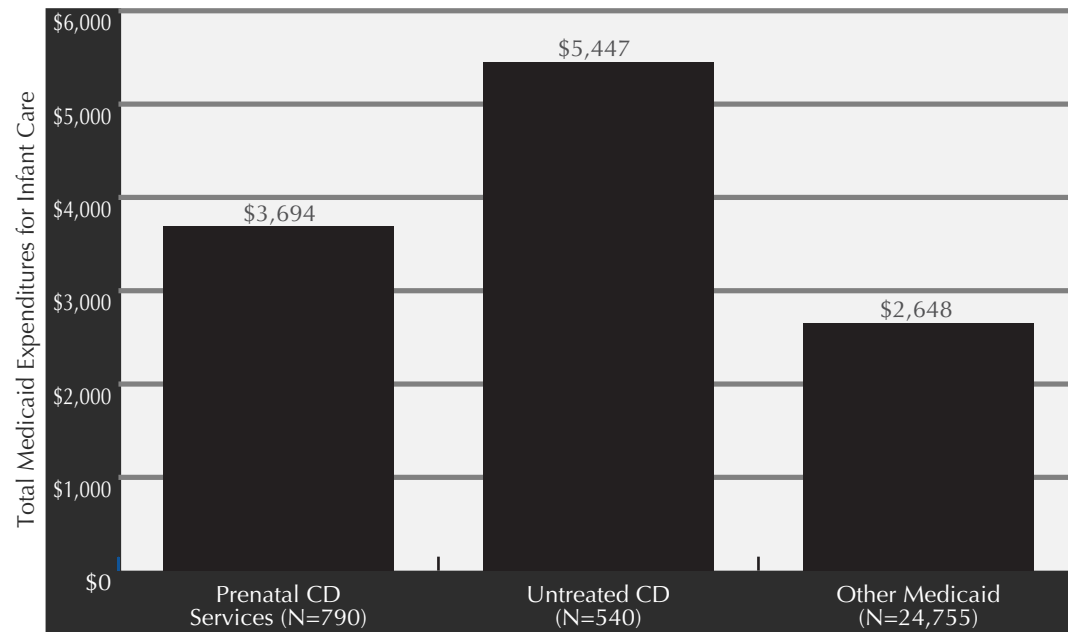
Source: Cawthon, L., & Schrager, L. "Substance Abuse Treatment and Birth Outcomes for Pregnant and Postpartum Women in Washington State." *First Steps Database* 5(1). Washington State Department of Social and Health Services, 1995.

Fetal death, or stillbirth, is associated with pregnancies complicated by maternal health conditions, including substance abuse. *Healthy People 2010* notes that, "Early, comprehensive, and risk-appropriate care to manage such conditions has contributed to reductions in fetal mortality rates."¹

This graph indicates that chemical dependency treatment during pregnancy is associated with much lower rates of fetal death among substance-abusing low-income women.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4. Washington, DC: 2000.

Average Medicaid Costs During the First Two Years of Life were Lower for Infants Born to Women Who Received Chemical Dependency Treatment in the Prenatal Period than for Those Born to Substance-Abusing Women Who Did Not Receive Treatment.



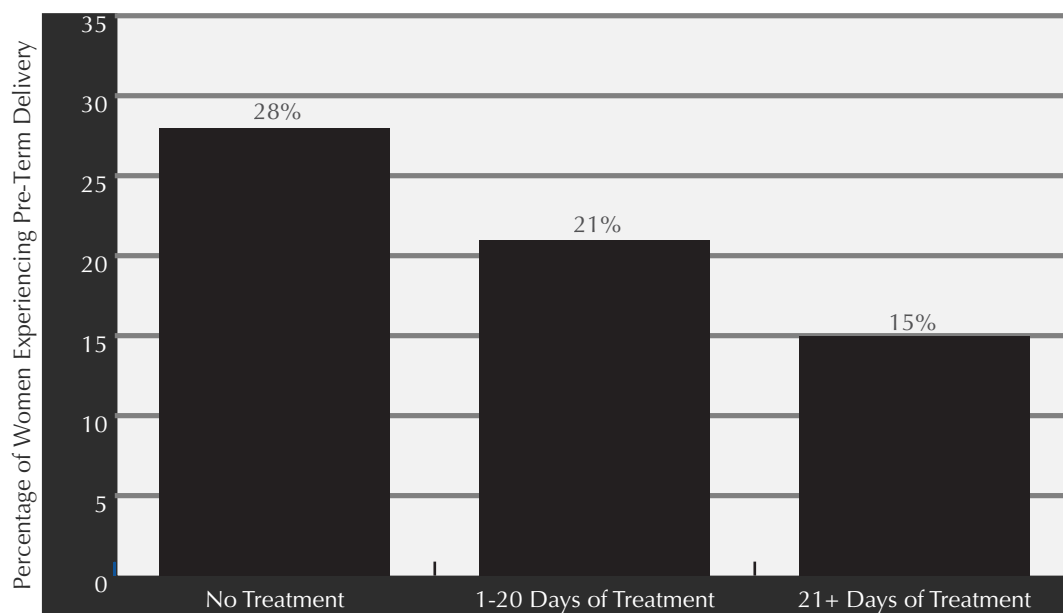
Source: Cawthon, L., & Schrager, L. "Substance Abuse Treatment and Birth Outcomes for Pregnant and Postpartum Women in Washington State." *First Steps Database* 5(1). Washington State Department of Social and Health Services, 1995.

Low birth weight (LBW – newborn infants weighing less than 5.5 pounds, or 2,500 grams) is the single most important factor in determining infant medical care expenditures during the neonatal period. Alcohol and other drug use is associated with LBW.¹

This graph indicates that average Medicaid expenditures for care during the first two years of life for infants born to untreated substance abusers was 47.5% higher than for substance-abusing women who received chemical dependency treatment during pregnancy, and more than twice that for infants born to non-substance abusing women receiving Medicaid.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

Pregnant, Substance-Abusing Women Who Receive 21+ Days of Chemical Dependency Treatment are Much Less Likely to Experience a Pre-Term Delivery Than Women Who Do Not Receive Treatment.



Source: Washington State Division of Alcohol and Substance Abuse. *Washington State MOMS Project: Perinatal Research and Demonstration Project – Final Report*. Olympia, WA: 1999.

A 1999 National Institute on Drug Abuse-funded study of the MOMS Project, which delivered woman-specific chemical dependency treatment services to pregnant women in Washington State in need of them, found a 46.4% reduction in pre-term deliveries for women who remained in treatment for 21 days or longer. Treatment was also associated with lower rates of fetal or infant death, lower rates of placental abruption, and improved birth outcomes.

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Patients

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Treatment

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Profile of ADATSA Patients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of patients admitted to publicly funded chemical dependency treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) in Washington State in SFY 2002 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	4,036
<i>Median Age:</i>	35
<i>Gender:</i>	64% Male; 36% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 3%; Unemployed – 97%
<i>Primary Drug:</i>	Alcohol – 44%; Stimulants (including Methamphetamine) – 25%; Marijuana – 11%; Cocaine/Crack – 11%
<i>Criminal Justice Involvement:</i>	64% arrested at least once in previous year
<i>% with Children in the Home:</i>	18%
<i>Housing Status:</i>	19% homeless*

Enacted in 1987, the ADATSA legislation created a program to treat adults addicted to alcohol or other drugs. To qualify, clients must be indigent, unemployable, and incapacitated due to their addiction. Patients may be admitted to either residential or outpatient modalities of treatment as individually required. The immediate goal of the program is abstinence, while ancillary goals include improved personal coping skills, as well as social and vocational skills. Success in moving toward these goals is expected to result moving toward the long-term objective of self-sufficiency.

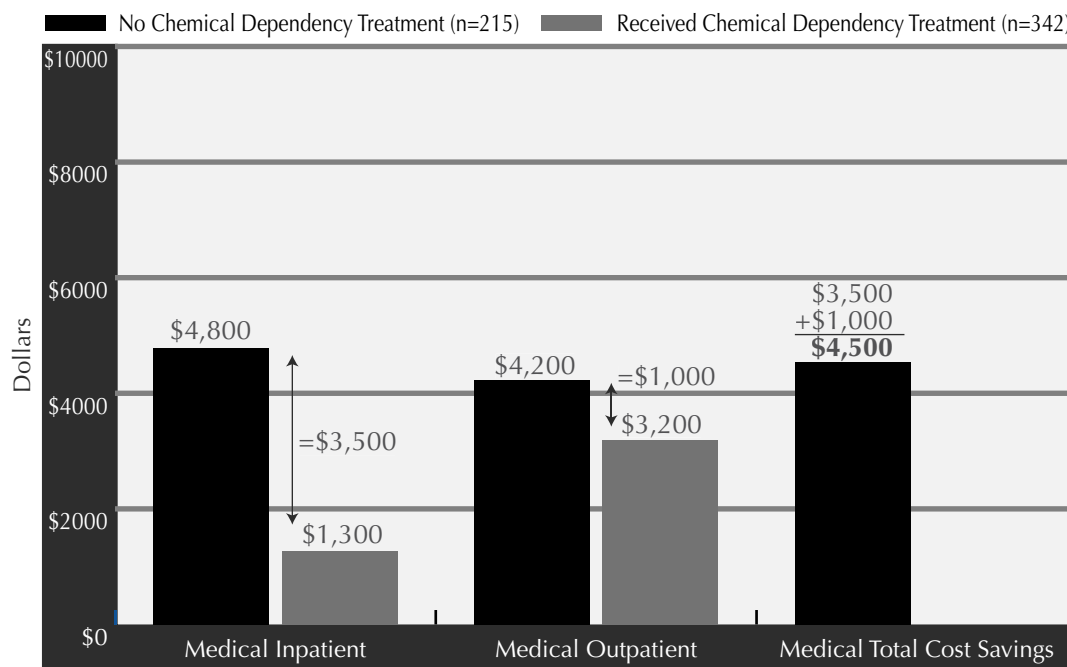
The average ADATSA patient has had a 15-year history of substance abuse, starting at age 16, with one or more prior treatment episodes. Approximately two-thirds are white, and one-third ethnic minorities. A significant proportion of patients suffer from physical, mental, or emotional problems in addition to their addiction.²

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Van Der Hyde, V., et al., *ADATSA Follow-Up Study of Extended Outpatient Care: A Comparison of 90 Days Versus 180 Days of Outpatient Treatment for Clients of Washington State's Alcoholism and Drug Addiction Treatment and Support Act*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1995.

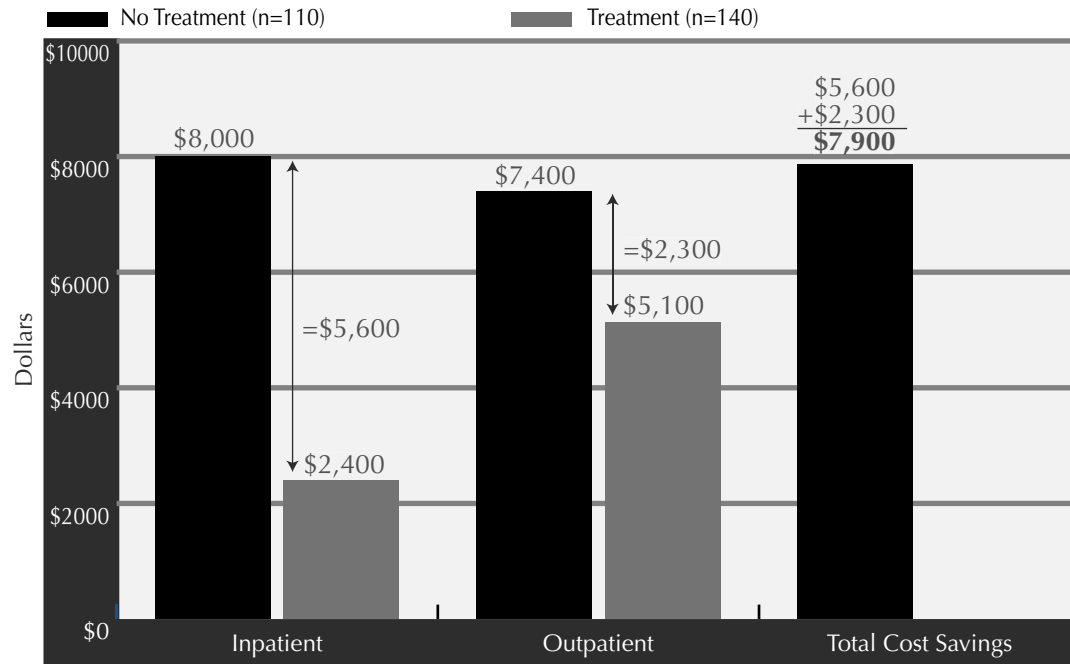
Average Medical Costs for ADATSA Patients Who Received Chemical Dependency Treatment were \$4,500 Lower than Those for Untreated Patients Over a Five-Year Follow-Up Period.



Source: Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This graph indicates that chemical dependency treatment can result in lower medical expenses. Over a five-year period, treated ADATSA patients had medical costs averaging \$4,500 less than those who did not receive treatment. Inpatient hospital expenses averaged \$3,500 less, while outpatient medical expenses averaged \$1,000 less.¹

For ADATSA Patients with Medicaid Medical Expenses Prior to Admission, Chemical Dependency Treatment was Associated with \$7,900 in Overall Savings in Medical Expenses Over a Five-Year Follow-Up Period.

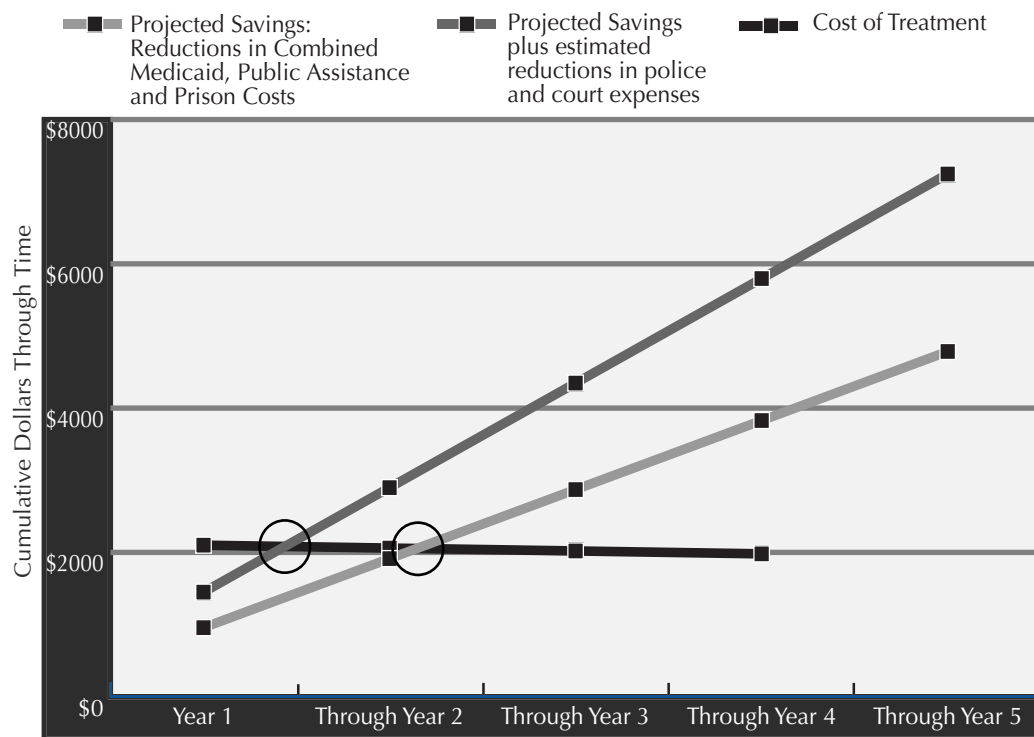


Source: Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This graph indicates striking savings in medical expenses for ADATSA patients, with Medicaid medical expenses prior to admission, in the five years following chemical dependency treatment. Overall savings totaled \$7,900 — \$2,300 in hospital inpatient, and \$5,600 in medical outpatient expenses.¹ Chemical dependency treatment is a wise investment, both in the health of ADATSA patients, and in reducing overall health expenses.

¹ Luchansky, B., & Longhi, D., *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Service, Research and Data, Analysis, 1997.

Chemical Dependency Treatment Provided to ADATSA Patients Results in Reduced Costs to the Public Over a Five-Year Follow-Up Period.



Source: Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This five-year comparison of projected incremental savings with projected treatment costs for ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) patients shows that the overall incremental savings are \$7,200, while the cumulative treatment costs total \$1,940. This means that every additional dollar spent on the treatment group results in \$3.71 in savings by the end of the five-year period. When estimated reductions in police and court expenses are added to the projections, the break-even point between costs and savings occurs much sooner. Additional funds spent on treatment pay for themselves in just over one year.

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Patients

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Profile of Supplemental Security Income (SSI) Recipients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

A profile of SSI recipients admitted to publicly funded chemical dependency treatment in Washington State in SFY 2002 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	1,856
<i>Median Age:</i>	41
<i>Gender:</i>	57% Male; 43% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 4%; Unemployed – 96%
<i>Primary Drug:</i>	Alcohol – 43; Heroin – 20%; Marijuana – 12%
<i>Criminal Justice Involvement:</i>	34% arrested at least once in previous year
<i>% with Children in the Home:</i>	21%
<i>Housing Status:</i>	13% homeless*

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

Chemical Dependency Treatment Lowers Medical Costs among Supplemental Security Income (SSI) Recipients.*



The Department of Social and Health Services' Research and Data Analysis Division examined medical and chemical dependency treatment records for nearly 129,000 adult Social Security Income (SSI) recipients to determine need for and receipt of chemical dependency treatment services.¹ Some 16% were found to be in need of treatment, and, of these, 50% received treatment between July 1997 and December 2001.

Medical, mental health, and nursing home cost differences between those who received treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical expenses, and also subtracting costs of chemical dependency treatment, average monthly costs were \$252 higher per month for individuals who did not receive treatment than for those who received at least some treatment. The differential was even greater for those completing chemical dependency treatment.

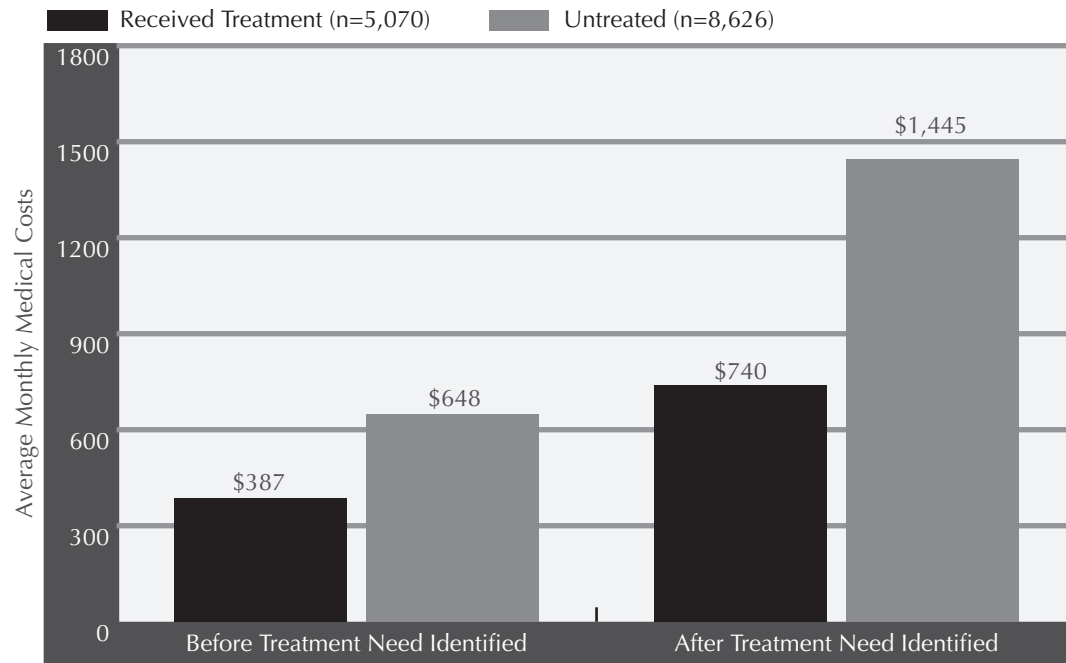
If an additional 30% of the 10,572 untreated SSI clients in need of chemical dependency treatment were to receive it, annual costs savings would amount to approximately \$9.6 million.

At least partially as a result of savings to the Medical Assistance program recognized by an earlier progress report of this study, \$2.94 million was allocated in the 2001-2003 Biennium to provide chemical dependency treatment for an average of an additional 60 clients per month.

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*



Chemical Dependency Treatment is Associated with Much Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.



Source: Estee, S. & Nordlund, D. (2001). *Washington State Supplemental Security Income Cost Offset Pilot Project: 2001 Progress Report*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis.

Medical and chemical dependency treatment records for nearly 104,000 adult Social Security Income (SSI) recipients were examined to determine need for, and receipt of, chemical dependency treatment services. Of these recipients, 13% were in need of treatment, and 38% of those in need received treatment between July 1997 and December 2000.

Medical cost differences between those who received treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, the average monthly medical costs were \$540 higher for those not receiving chemical dependency treatment than for those who received at least some treatment, or a yearly cost differential of \$6,480. The Division of Alcohol and Substance Abuse has now expanded services in its SSI Cost Offset Pilot Project, and is contracting with the Department of Social and Health Services, Research and Data Analysis Division, to examine differences in mental health and criminal justice costs and in mortality resulting from chemical dependency treatment.

¹Estee, S., & Nordlund, D. (2001). *Supplemental Security Income (SSI) Cost Offset Pilot Project: 2001 Progress Report*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis.

Chemical Dependency Treatment is Associated with Much Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.*



The Department of Social and Health Services' Research and Data Analysis Division examined medical and chemical dependency treatment records for nearly 129,000 adult Social Security Income (SSI) recipients to determine need for, and receipt of, chemical dependency treatment services.¹ They then matched costs for those who needed chemical dependency treatment and received it between July 1997 and December 2001 with those who were in need but did not receive treatment.

For those who received any treatment:

- Medical costs were \$311 per client per month lower;
- State mental hospital expenses were \$48 per client per month lower;
- Community psychiatric hospital costs were \$16 per client per month lower;
- Community mental health services costs were \$17 per client per month higher;²
- Nursing home costs were \$56 per client per month lower.

The total reduction in costs for medical, mental health, and selected adult services for those who entered chemical dependency treatment was \$414 per client per month.

For those who completed treatment, the reduction was \$530 per client per month.

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

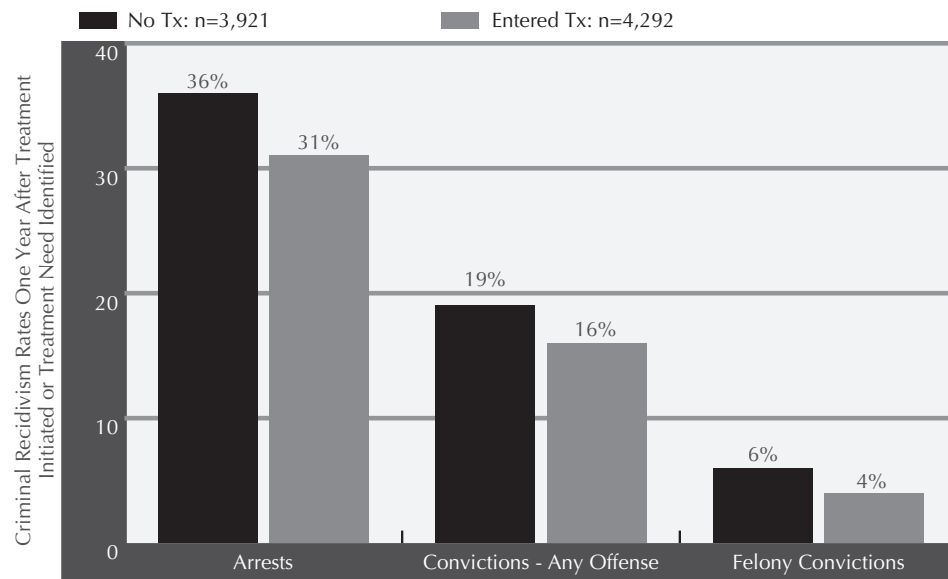
¹ Estee, S. and Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2003.

² The increased community outpatient mental health service costs for those who entered chemical dependency treatment should be viewed favorably, since these services are often incorporated into successful treatment plans for those who are dealing with chemical dependency and other health related issues. Without treatment, patients may have ended up in much more restrictive (and expensive) inpatient psychiatric settings.



Chemical Dependency Treatment is Associated with Fewer Criminal Arrests and Convictions Among Supplemental Security Income (SSI) Recipients.*

Criminal Recidivism Rates One Year After Treatment Initiated or Treatment Need Identified



Source: Estee, S. and Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Washington Department of Social and Health Services, Research and Data Analysis Division, February 2003.

The Department of Social and Health Services' Research and Data Analysis Division examined criminal arrest and conviction and chemical dependency treatment records for nearly 129,000 adult Social Security Income (SSI) recipients.¹ Some 8,743 SSI recipients were found to have an arrest or conviction in the two years prior to initiating chemical dependency treatment or having a need for such treatment indicated. In the following year, those who entered treatment were found to be 16% less likely to have been arrested, and 34% less likely to have a felony conviction compared to those who did not enter treatment. Similarly, among clients who entered chemical dependency treatment and had a recent record of arrest or conviction, those who completed chemical dependency treatment were 43% less likely to be arrested, and 48% less likely to be convicted of a felony.²

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

¹ Estee, S. and Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2003.

² Percentages are based on multivariate proportional hazards models that take account of age, gender, and race/ethnicity. See *Ibid.*, pp. 31-35 for details.

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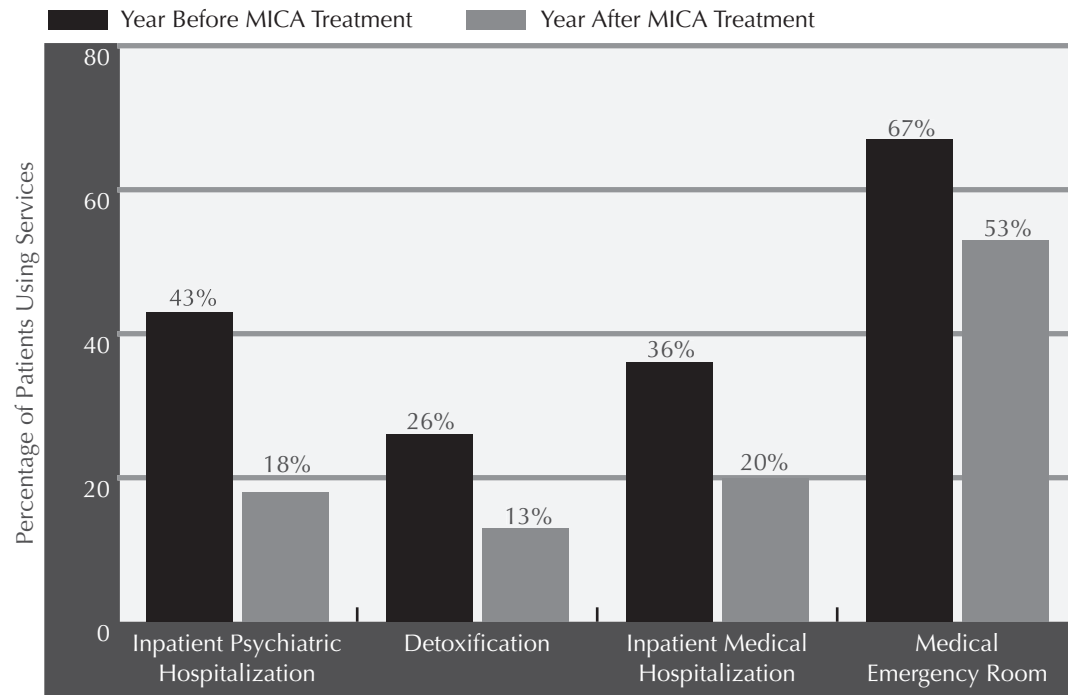
Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



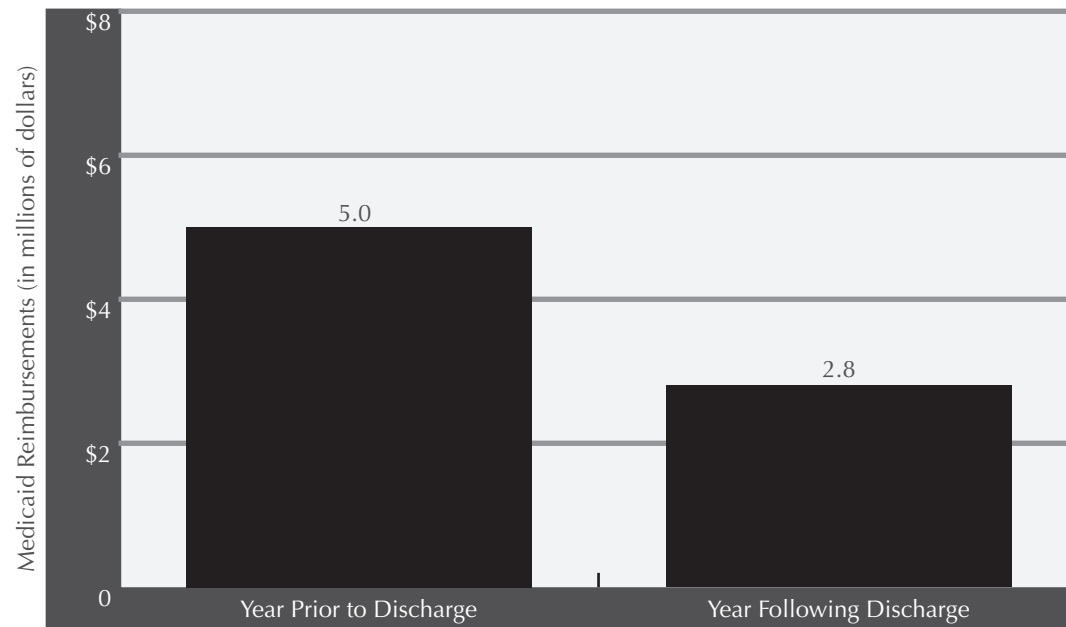
Mentally Ill Chemically Abusing Patients Utilize Fewer Medicaid Services Following Discharge from Residential Treatment.



Source: Maynard, C., et al. "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

A significant number of Medicaid patients are diagnosed with both mental illness and substance abuse disorders. Treating these "co-occurring" disorders in an integrated manner has proven effective in enhancing health-related outcomes. This graph indicates that Medicaid expenses for patients with co-occurring disorders receiving coordinated services in a residential setting decreased overall by 44% in the year following discharge from the year prior to discharge.

Use of Expensive Acute Care Services Decreased for Mentally Ill Chemical Abusing Patients Following Discharge from Integrated Residential Treatment.



Source: Maynard, C., et al. "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

Integrated mental illness/chemical dependency treatment has proven effective in reducing use of acute care services for mentally ill chemical abusing ("co-occurring") patients following discharge. The percentage of patients requiring inpatient psychiatric hospitalization fell by 58%; detoxification by 50%; inpatient medical hospitalization by 44%; and use of emergency rooms by 21% in the year following discharge.

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Profile of Low-Income Adults Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of low-income admitted to publicly funded chemical dependency treatment in Washington State in SFY 2002 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	21,163
<i>Median Age:</i>	35
<i>Gender:</i>	60% Male; 40% Female
<i>Employment Status:</i>	Employed (full- or part-time) – 19%; Unemployed – 81%
<i>Primary Drug:</i>	Alcohol – 51%; Stimulants (including Methamphetamine) - 18%; Marijuana - 13%
<i>Criminal Justice Involvement:</i>	65% arrested at least once in previous year
<i>% with Children in the Home:</i>	34%
<i>Housing Status:</i>	13% homeless*

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, opiate substitution, transitional housing, private-pay, and Department of Corrections patients are excluded.

Publicly Funded Residential Chemical Dependency Treatment Results in Improved Outcomes in Employment and Medical Status, Lower Substance Use and Higher Rates of Abstinence, and Reduced Criminal Activity.



A 1999 study was undertaken by the University of Washington's Alcohol and Drug Abuse Institute to assess the quality and effectiveness of the Division of Alcohol and Substance Abuse's publicly funded adult residential chemical dependency treatment system. Some 577 low-income patients were assessed at admission to treatment, and six months following their discharge. The study found:

- Patients were much less likely to use alcohol and illegal drugs following treatment. Self-reported abstinence rates for alcohol use in the past 30 days increased by 87%, and by 109% for drug use. Of those who continued to report any drug use, the percentage of patients who used any illegal drugs for seven or more of the past 30 days declined 74%, from 50% at treatment admission to 13% at follow-up.
- The average number of self-reported days of illegal activity declined 85%. Average 30-day earnings from illegal activity declined 93%, from \$485 at admission to \$32 at follow-up.
- In the 30 days prior to admission to treatment, only 19.8% of patients worked ten or more days. In the 30 days prior to the six-month post-discharge follow-up, 40.7% worked ten or more days, representing a 94% increase. Average monthly income increased from \$159 at admission to \$568 at follow-up.
- The percentage of patients reporting no days of medical problems during the past 30 days increased by 25% at the post-discharge follow-up. The number of days with mental health distress was reduced by 48%.
- The number of days with significant family conflict during the past 30 days declined by 62% at the post-discharge follow-up.¹



Profile of Adults Receiving Temporary Assistance for Needy Families Served By Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of patients receiving Temporary Assistance for Needy Families (TANF) admitted to publicly funded chemical dependency treatment in Washington State in SFY 2002 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	3,288
<i>Median Age:</i>	30
<i>Gender:</i>	26% Male; 74% Female
<i>Employment Status:</i>	Employed (full- or part-time) – 10%; Unemployed – 90%
<i>Primary Drug:</i>	Alcohol – 36%; Stimulants (including Methamphetamine) - 24%; Marijuana 21%
<i>Criminal Justice Involvement:</i>	54% arrested at least once in previous year
<i>% with Children in the Home:</i>	80%
<i>Housing Status:</i>	6% homeless*

A study of adults receiving TANF admitted to publicly funded chemical dependency treatment in Washington State, July 1998 – June 1999, indicated:

- One out of three women did not have a high school diploma or GED.
- Three out of four women reported they had been victims of domestic violence at some point in their lives.
- 21% reported receiving mental health treatment in the previous year.
- One out of three women reported using injection drugs at some point in the lives.²

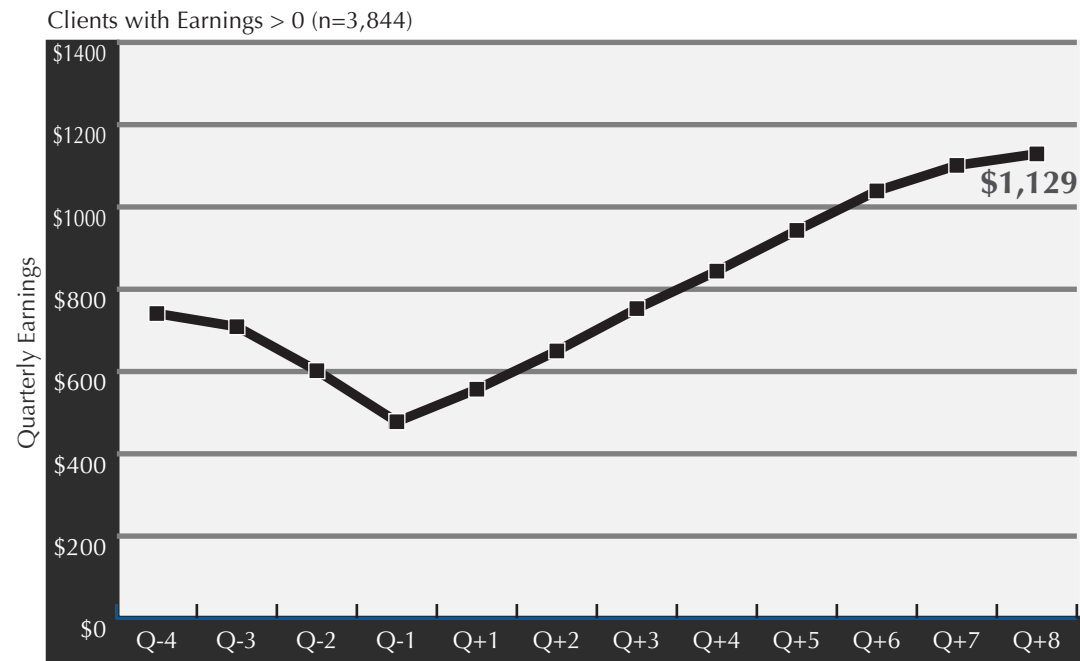
Research has shown that timely access to quality chemical dependency treatment can play a major role in moving individuals off public assistance and toward healthy lifestyles and self-sufficient lives.

* Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, transitional housing, private-pay, and Department of Corrections patients are excluded.

² Rodriguez, F. *Key Characteristics of TANF Adults Admitted to Publicly Funded Treatment in Washington State, July 1998 – June 1999*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2000.

AFDC Clients Who are Employed Show Major Increases in Earnings Following Chemical Dependency Treatment.



Source: Wickizer, T., et al. "Employment Outcomes Among AFDC Recipients Treated for Substance Abuse in Washington State," *The Millbank Quarterly* 78(4), 2000.

This graph indicates that chemically dependent clients receiving AFDC ("Aid to Families with Dependent Children") support showed marked declines in employment income in the year prior to receiving chemical dependency treatment, and more than doubled their average employment income in the two years following treatment. AFDC in Washington State has now been replaced by TANF ("Temporary Assistance for Needy Families"). This 2000 study confirms the results of earlier studies indicating that chemical dependency treatment assists low-income patients in moving toward self-sufficiency.

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Abusing Patients

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



Profile of Patients Receiving Publicly Funded Opiate Substitution Treatment in Washington State

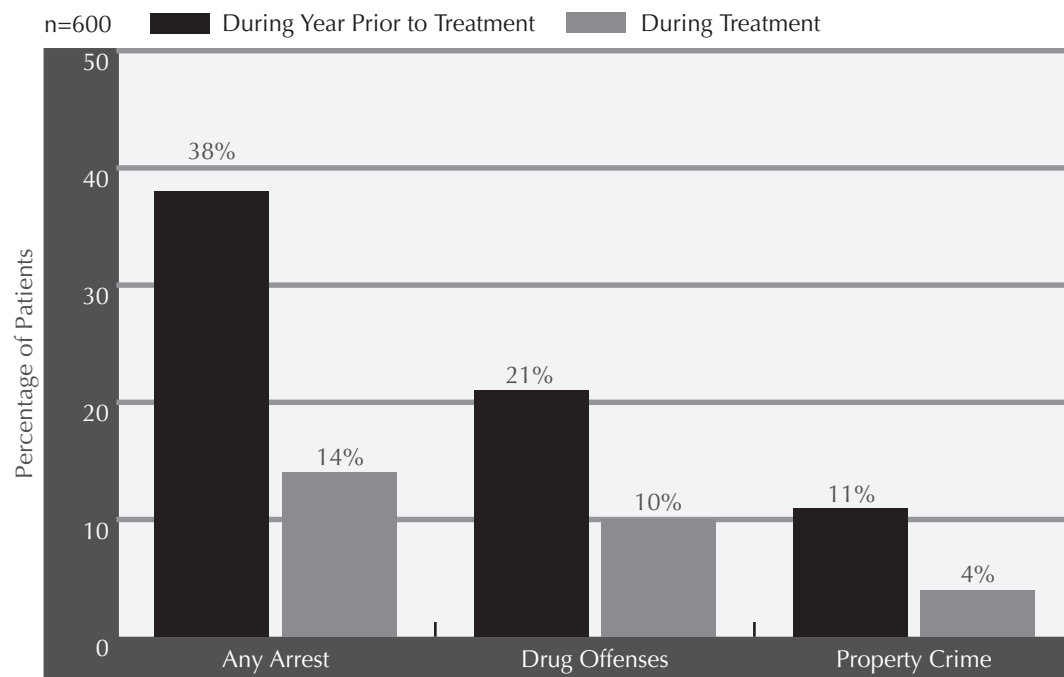
A profile of patients admitted to publicly funded opiate substitution treatment in Washington State in SFY 2002 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	966
<i>Median Age:</i>	43
<i>Gender:</i>	51% Male; 49% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 13%; Unemployed – 87%
<i>Primary Drug:</i>	Heroin – 97%; Other – 3%
<i>Criminal Justice Involvement:</i>	34% arrested at least once in previous year
<i>% with Children in the Home:</i>	22%
<i>Housing Status:</i>	17% homeless*

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Research and Evaluation Section, Washington State Division of Alcohol and Substance Abuse, July 2003. Data include unduplicated admissions to treatment; detoxification, opiate substitution, transitional housing, private-pay, and Department of Corrections patients are excluded.

Criminal Arrests Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



Source: Baxter, B., and Albert, D., *Report to the Legislature: Determining the Value of Opiate Substitution Treatment*. 2002.

This graph indicates that patients receiving publicly funded opiate substitution treatment are less likely to be arrested for a crime during treatment than in the year prior to treatment.

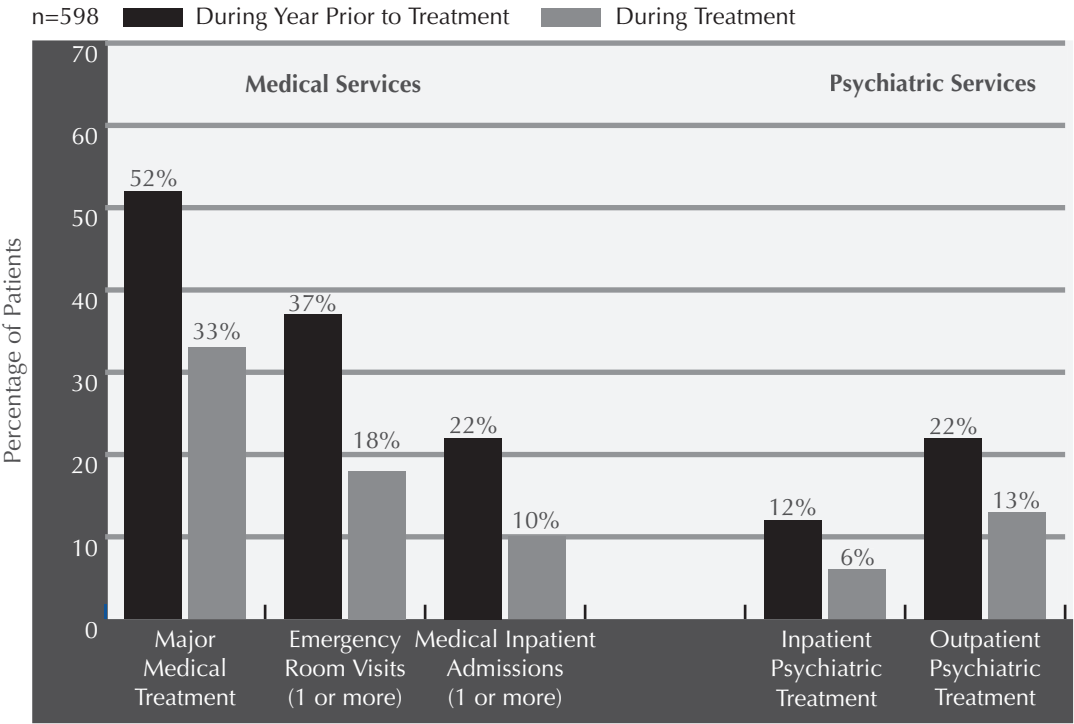
It is estimated that almost 30,000 Washington State residents have been dependent upon opiates (primarily heroin) during their lifetime.¹ Thirteen opiate substitution clinics currently provide opiate substitution treatment through administration of medication (e.g., methadone) and provision of counseling services. In addition, patients receive education, random urine drug screening to monitor drug use, and are subject to stringent rules regarding compliance. In SFY 2001, 4,766 patients were enrolled in opiate substitution treatment programs in Washington State, 2,492 (52.3%) of whom were publicly funded.²

¹ Kohlenberg, E., Yetter, R., and Mack, C., *Needs Assessment Data Project: Division of Alcohol and Substance Abuse, Fiscal Year 1990*. Olympia, WA: Department of Social and Health Services, Office of Research and Data Analysis, Planning, Research and Development, 1992.

² Data do not include patients enrolled in Veterans Administration programs.



Health Care Utilization Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



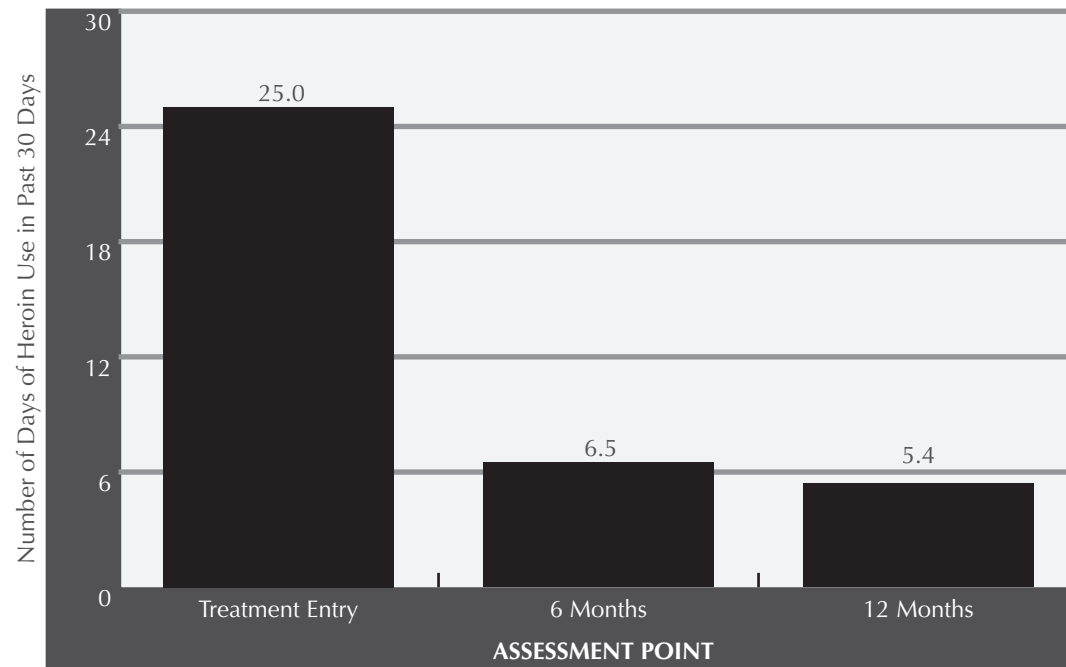
Source: Baxter, B., and Albert, D. *Report to the Legislature: Determining the Value of Opiate Substitution Treatment*. 2002.

Opiate substitution treatment has been scientifically shown to work. The federal Office of National Drug Control Policy called methadone therapy, “one of the longest-established, most thoroughly evaluated forms of drug treatment.”¹ A Consensus Panel convened by the National Institutes of Health in 1997 concluded, “Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity.”²

This graph indicates that patients receiving publicly funded opiate substitution treatment use fewer health care and psychiatric services during treatment than in the year prior to treatment. This results in significant cost savings throughout the health care system.

¹ Office of National Drug Control Policy, *The National Drug Control Strategy: 2000 Annual Report*. Washington, DC: Office of the White House, 2000.
² National Institutes of Health, *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*. November 17-19, 1997 15(6).

Patients Receiving Opiate Substitution Treatment Show Significant Decreases in Heroin Use.



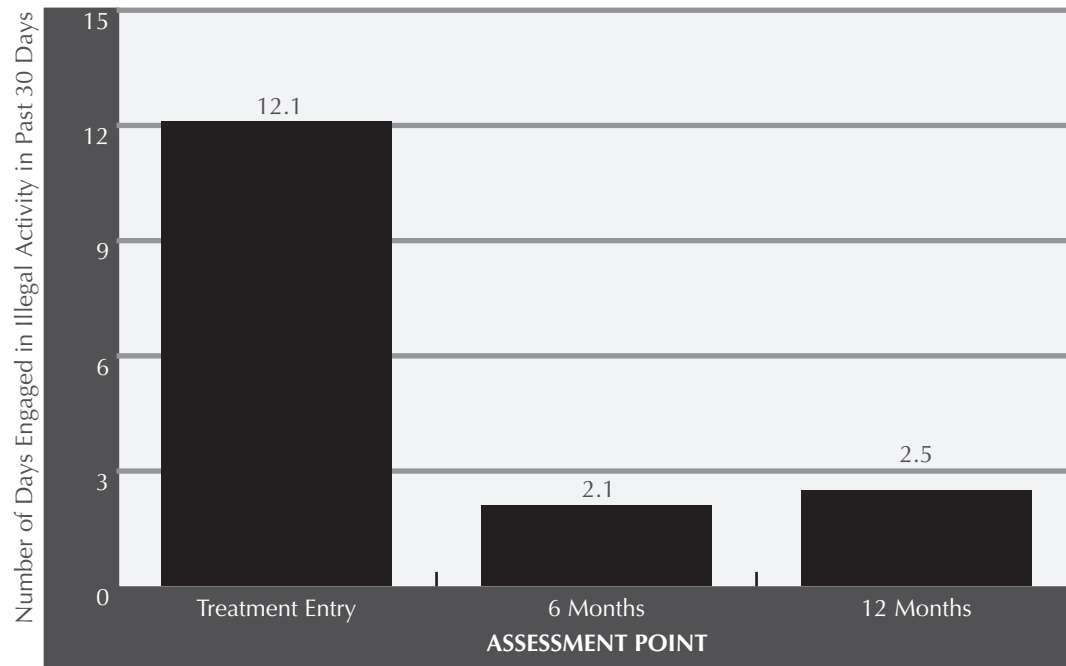
Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

A 2003 study of 135 patients admitted to publicly funded opiate substitution treatment in Washington State in 2000 demonstrated significant reductions in the average number of days they engaged in heroin use. At entry into treatment, patients reported an average of 25 days of heroin use in the past 30 days. At six months, this was reduced to 6.5 days, and at 12 months, to 5.4 days, representing a 78% decline. More than four out of five patients reported a reduction in the number of days using heroin at the six- and 12-month follow-ups.¹

¹ Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.



Patients Receiving Opiate Substitution Treatment Show Significant Decreases in Days Engaged in Illegal Activity.



Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

A 2003 study of 135 patients admitted to publicly funded opiate substitution treatment in Washington State in 2000 demonstrated significant reductions in the average number of days they engaged in illegal activity. At entry into treatment, patients reported an average of 12.1 days of illegal activity in the past 30 days. At six months, this was reduced to 2.1 days, and at 12 months, to 2.5 days, representing a 79% decline. Some 39% of patients reported zero days using of illegal activity at the six- and 12-month follow-ups.¹

¹ Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Mentally Ill
Chemically
Abusing Patients

Low-Income
Patients

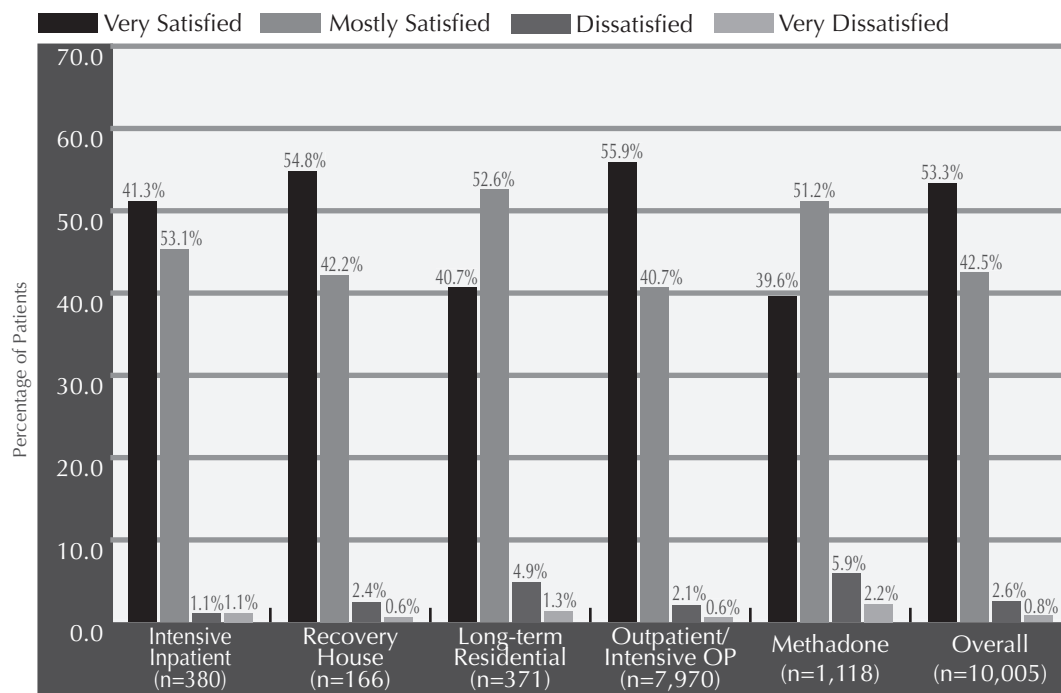
Patients Receiving
Opiate Substitution
Treatment

**Patient
Satisfaction**



In 2002, 96% of Patients Receiving Chemical Dependency Treatment Services Reported Overall Satisfaction with the Services They Received.

“In an overall, general sense, how satisfied are you with the services you have received?”



Source: Rodriguez, F., *Clients Speak Out 2002: Second Annual Statewide Client Satisfaction Survey*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

In March 2002, DASA conducted its second statewide client satisfaction survey. It was administered at 269 treatment centers to 12,000 patients, or 77% of those receiving treatment in the participating agencies during the week of the survey.

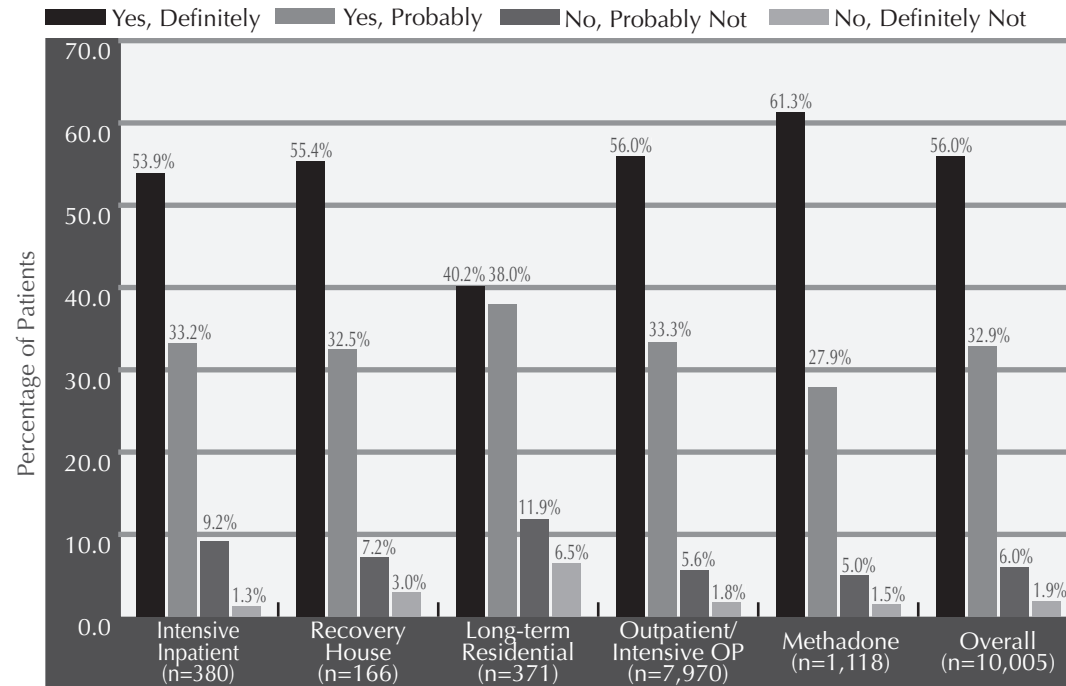
Overall, 96% of adult patients reported they were satisfied with the comfort and appearance of their treatment facility; 81% said they were always treated with respect by staff; 91% rated group sessions as helpful; and 87% reported they found individual counseling to be helpful.¹ Reports of responses to the survey were sent to each of the respective treatment agencies for use in quality improvement activities.

¹ Rodriguez, F., *Clients Speak Out 2002: Second Annual Statewide Client Satisfaction Survey*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

In 2002, 89% of Patients Receiving Chemical Dependency Treatment Services Reported They Would Return to the Same Program If They Needed Help Again.



“If you were to seek help again, would you come back to this program?”



Source: Rodriguez, F., *Clients Speak Out 2002: Second Annual Statewide Client Satisfaction Survey*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

In March 2002, DASA conducted its second statewide client satisfaction survey. It was administered at 269 treatment centers to 12,000 patients, or 77% of those receiving treatment in the participating agencies during the week of the survey.

Many patients receiving chemical dependency treatment services require other services as well. Treatment agencies play a key role in assisting patients in identifying and accessing these services. Of those reporting a need for them: 73% of adult patients said their treatment program was helpful in connecting them to legal services; 78% to medical services; 73% to family services; 71% to mental health services; 59% to educational or vocational services; and 52% to employment services.¹

Treatment Completion





Treatment Completion Improves Patient Outcomes

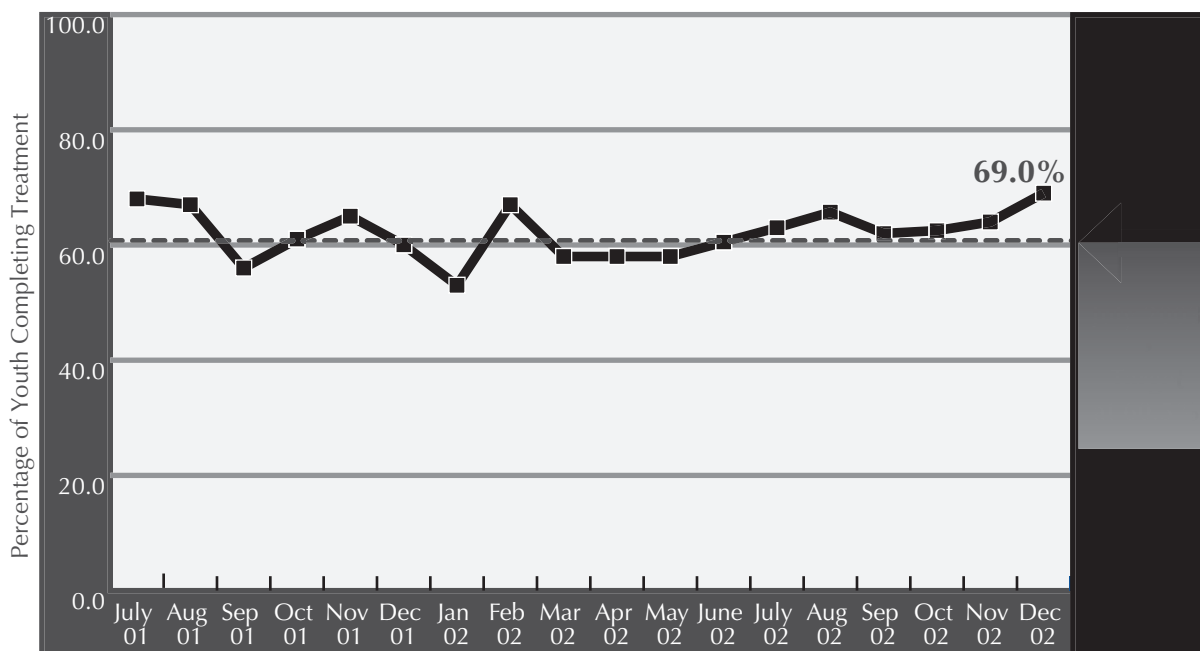
As part of the Department of Social and Health Services' pledge to ensure better outcomes for the state residents it serves, the Division of Alcohol and Substance Abuse (DASA) has committed itself to improving completion and retention rates for publicly funded patients receiving chemical dependency treatment.

Multiple studies, conducted in Washington State and elsewhere, demonstrate that outcomes following from treatment participation are significantly enhanced when patients complete treatment. For example, relative to patients who did not complete treatment, completers have been found to:

- *Have higher employment and wages following discharge from treatment;*
- *Be arrested and convicted less frequently after discharge;*
- *Have significantly fewer inpatient medical hospital admissions and are less likely to require emergency medical services after discharge;*
- *If pregnant, are more likely to have full-term deliveries, babies with higher birth weights, and fewer fetal or infant deaths; and*
- *Produce higher cost savings to public systems following discharge.*

In the pages that follow, results from studies that illustrate the above points are featured. All studies have been conducted in Washington State with publicly funded clients. Taken together, they suggest that improving treatment completion rates is one of the most powerful ways to maximize benefits from the limited public resources available to fund chemical dependency treatment. DASA is now working with researchers, counties, tribes, and both residential and outpatient treatment providers to set targets and incorporate best practices to improve completion rates throughout the state.

Residential Treatment Completion Rates for Youth Now Consistently Exceed the July 2003 Target of 60.5%.

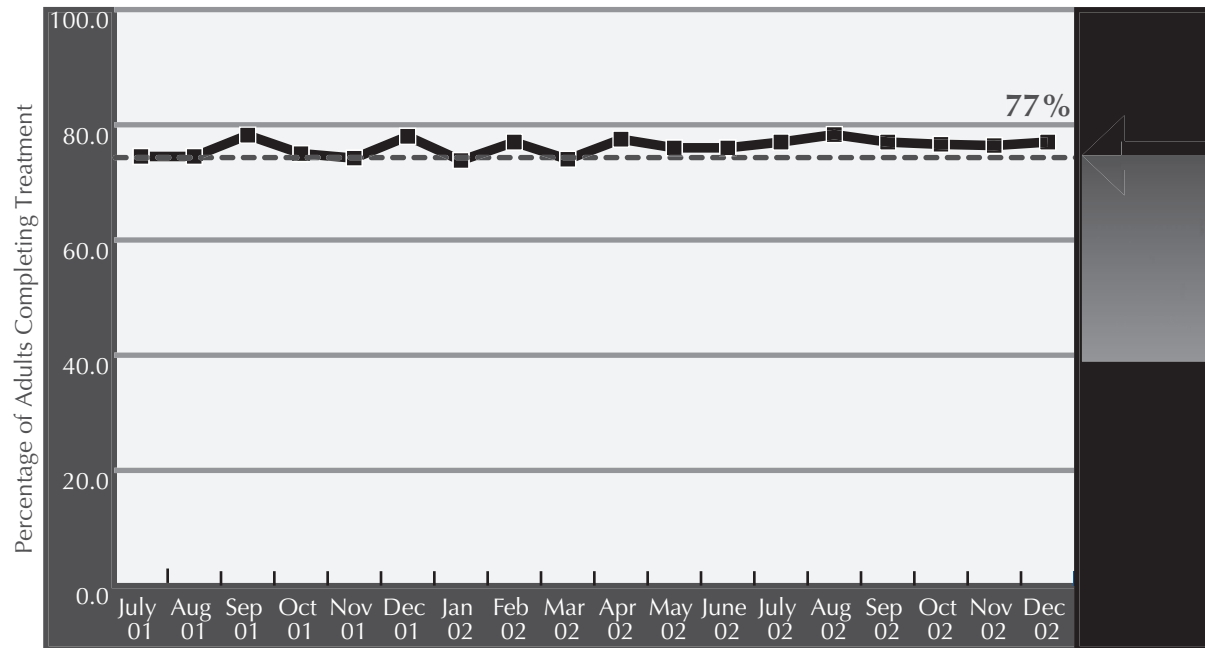


Source: Program Review, Division of Alcohol and Substance Abuse, February 2003

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income youth who complete publicly funded residential chemical dependency treatment. Research has shown that treatment completion is closely linked to better outcomes for both adults and youth. Cumulative data from July-December 2002 indicate that 65% of youth completed treatment.



Residential Treatment Completion Rates for Adults Now Consistently Exceed the July 2003 Target of 75%.



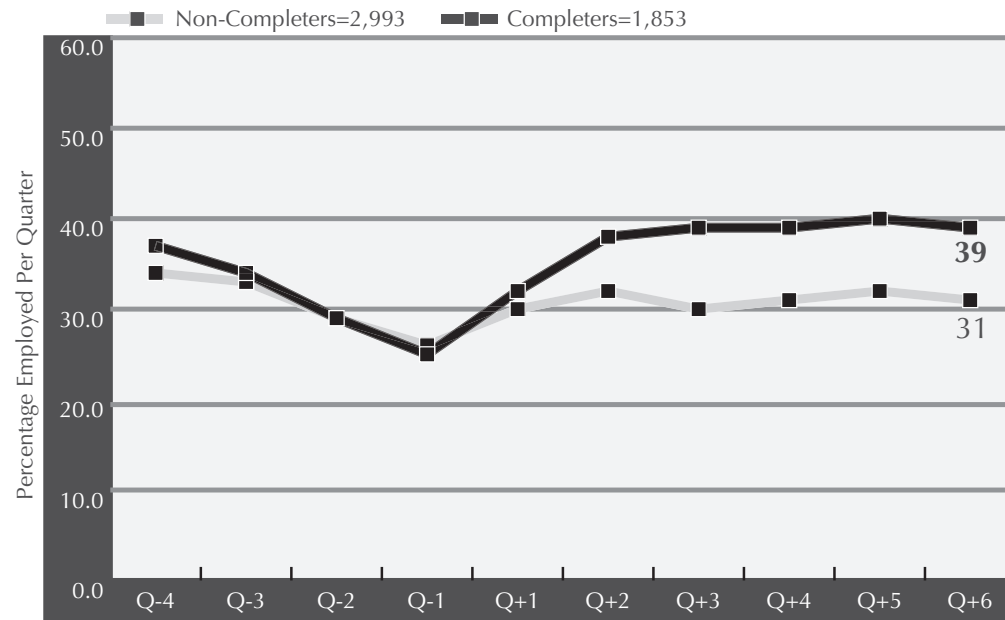
Source: Program Review, Division of Alcohol and Substance Abuse, February 2003

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income adults who complete publicly funded residential chemical dependency treatment. Research has shown that treatment completion is closely linked to better outcomes for both adults and youth. Cumulative data from July-December 2002 indicate that 76.5% of adults completed treatment.

Treatment Completers are More Likely to Become Employed After Treatment.



Percentage of ADATSA Patients Employed During the Four Quarters Before Admissions and Six Quarters After Discharge from Chemical Dependency Treatment



Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients¹, employment trends among treatment completers and non-completers were tracked. Prior to treatment, both completers and non-completers experienced declining rates of employment (see Quarters -4 through -1 on graph above). After treatment, employment rates rose for both groups, but the rise was significantly greater for completers: during the sixth quarter after treatment began, 39% of the completers were employed compared to 31% of the non-completers, representing a difference of 25.8%.²

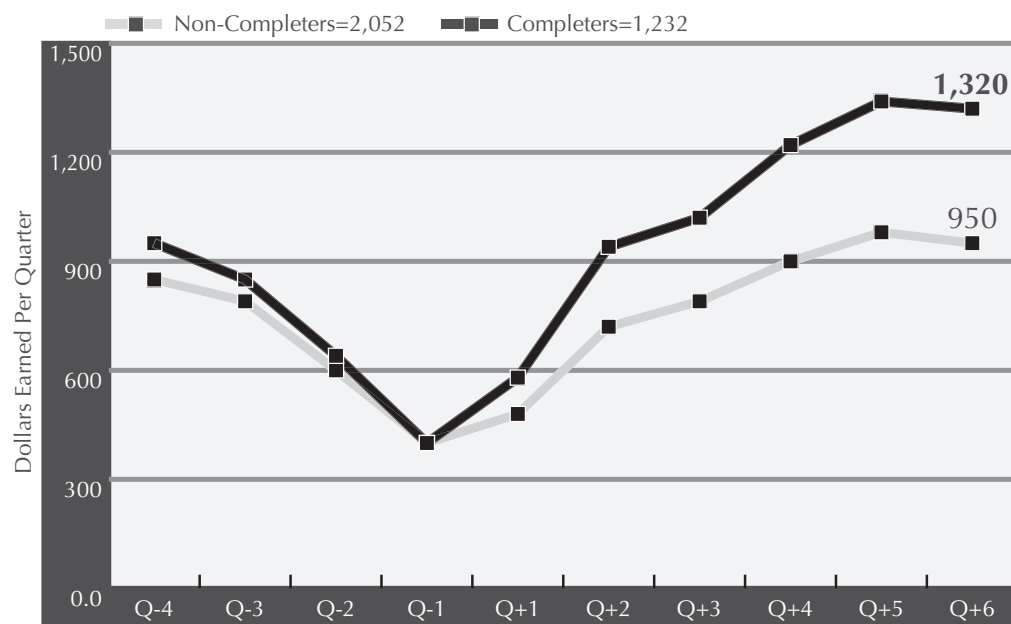
¹ ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.

² Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.



Treatment Completers Show Pronounced Post-Treatment Wage Increases.

Quarterly Wages for ADATSA Patients During Four Quarters Before Admission and Six Quarters After Discharge from Chemical Dependency Treatment



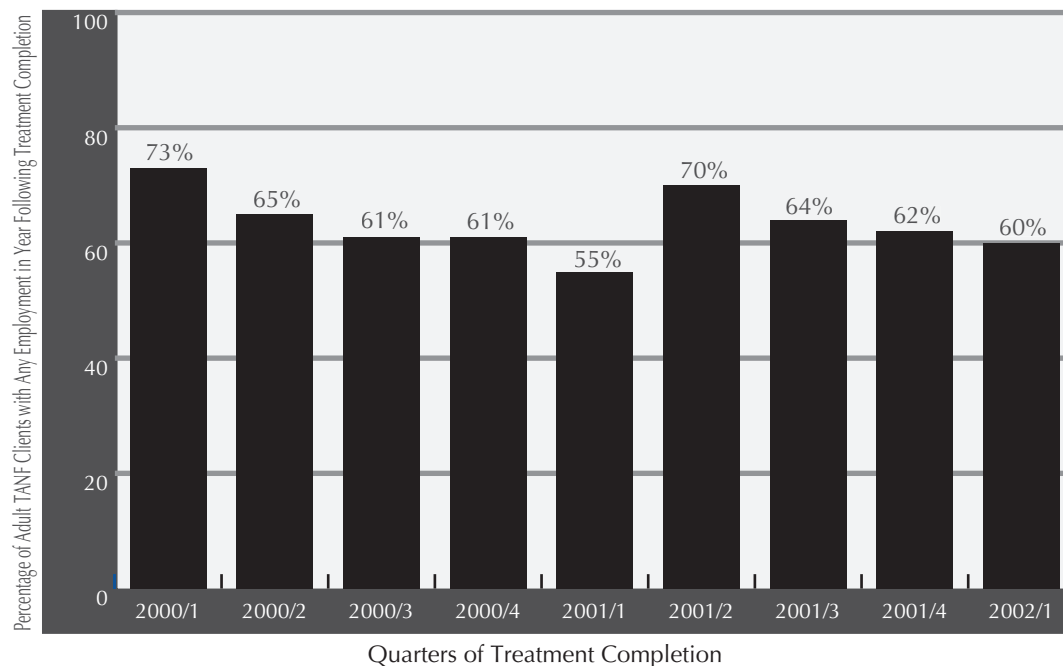
Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients¹, among those who were employed, it was found that pre-treatment wages for those who completed and those who did not complete chemical dependency treatment was similar. For both groups, wages began to decline four quarters before beginning treatment and continued to decline until treatment began. After treatment, wages rose for both groups. However, the increase in wages for treatment completers was more pronounced than for non-completers. During the sixth quarter after treatment began (see Q+6 on chart), completers earned \$1,316 on average, while non-completers earned \$941, a difference of \$375, representing a 39.8% difference.²

¹ ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.

² Luchansky, B., and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

Approximately Three Out of Five Adult Clients Enrolled in the Temporary Assistance for Needy Families (TANF) Program and Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.

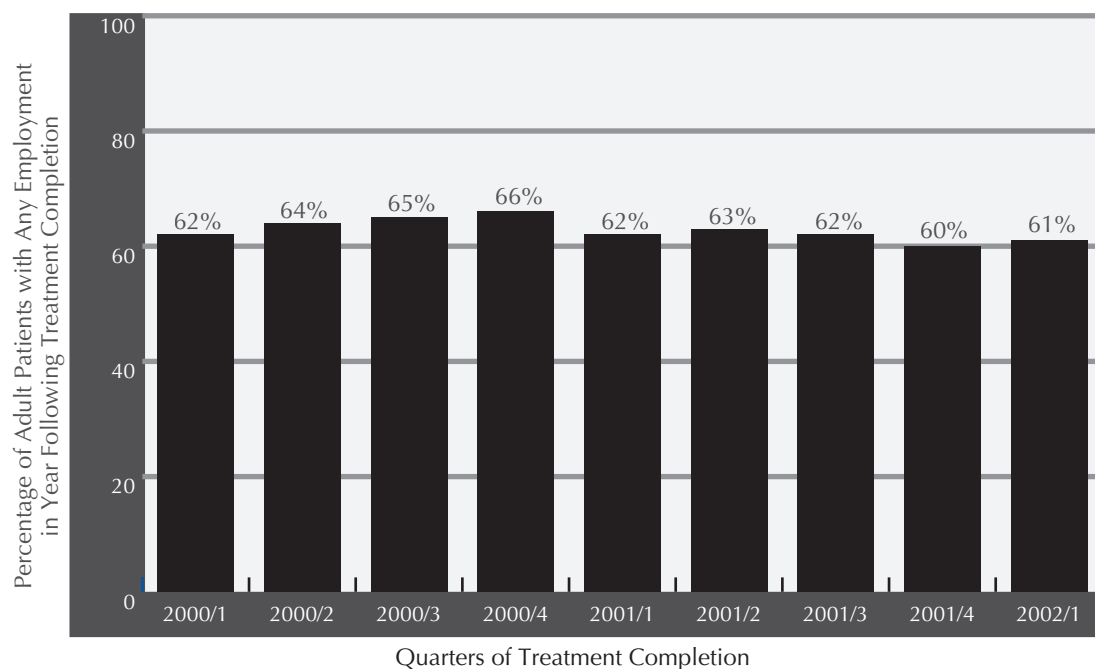


Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that of clients enrolled in the Temporary Assistance for Needy Families (TANF) program who completed chemical dependency treatment in the first quarter of SFY 2002, and did not require further treatment, 60% became employed in the following 12 months. Some 41% worked more than 20 hours a week; 51% earned wages above the Federal Poverty Level. For TANF clients with substance abuse problems, chemical dependency treatment helps move them toward economic self-sufficiency.



More than 60% of Adult Patients Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.



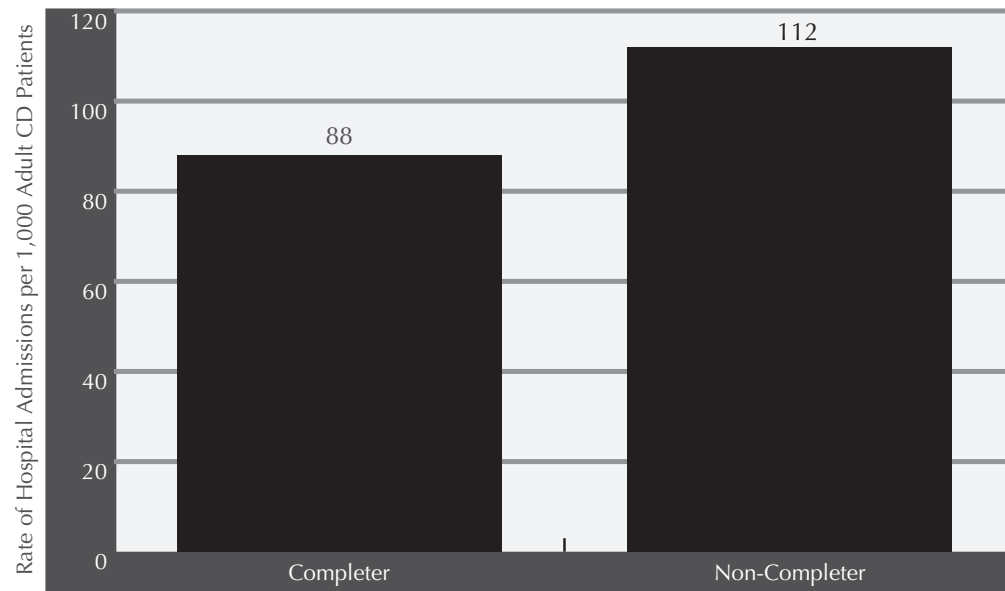
Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that more than three out of five adult low-income patients who completed chemical dependency treatment in the first quarter of SFY 2002, and did not require further treatment, became employed in the following 12 months. Average monthly wages were approximately \$925. More than half (53%) worked more than 20 hours a week; 59% earned wages above the Federal Poverty Level.

Treatment Completers Had Lower Hospital Admission Rates Following Chemical Dependency Treatment.



Adjusted Rates of Hospital Admissions per 1,000 Patients in the Year Following a Treatment Episode



Source: Luchansky, B., et al. *Substance Abuse Treatment and Hospital Admissions: Analyses from Washington State, 2002.*

A study of almost 10,000 adult patients who received publicly funded chemical dependency (CD) treatment in 1995 showed that patients who completed CD treatment were 21% less likely to be admitted to a hospital in the year following discharge compared to patients who did not complete treatment.¹



Completion of Treatment and Treatment Retention are Associated with Reduced Risk of Felony Arrests Among Adults, and Convictions Among Youth.

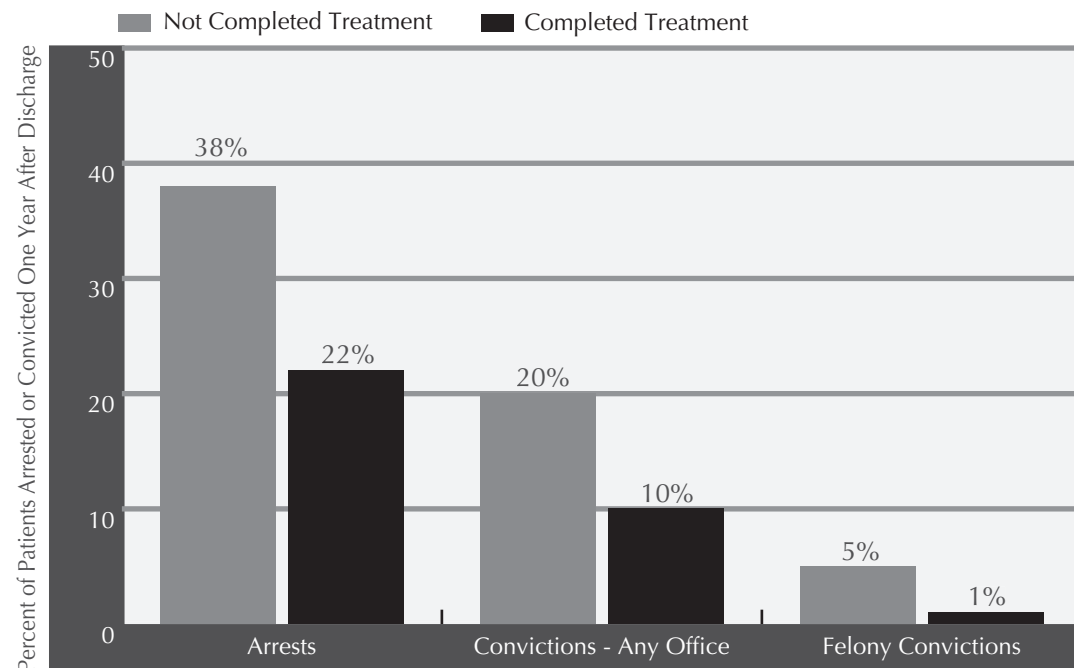
Research, both in Washington State and elsewhere, has consistently shown that admission to chemical dependency treatment is associated with lower crime rates, fewer arrests, and lower criminal justice costs. More recent studies highlight the benefits of both treatment completion and longer retention in treatment:

- A 2002 study of over 10,000 adult patients who received publicly funded chemical dependency treatment in 1995 demonstrated that the probability for a felony offense was 21% lower in the following year for patients completing treatment when compared to patients who did not complete treatment. For patients whose treatment episode was greater than 90 days, the probability of a felony arrest was 32% less than for patients with shorter treatment episodes.¹
- A 2003 study of almost 6,000 youth who participated in substance abuse treatment between 1997 and 1998 indicated that patients completing treatment had a 29% reduction in the risk of a subsequent felony conviction, and a 17% reduction in risk of any conviction in the year following discharge, compared to non-completers.²

¹ Luchansky, B., et al., *Substance Abuse Treatment and Arrests: Analyses from Washington State (Fact Sheet 4.42)*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, 2002.

² Luchanski, B., et al., *Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment*. Manuscript being prepared for publication, 2003.

Treatment Completion was Associated with Reductions in Arrests and Convictions Among Supplemental Security Insurance Recipients.*



Source: Estee, S., & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*.

A study completed in 2003 indicates that Supplemental Security Income (SSI) recipients who completed chemical dependency treatment had lower rates of arrest, convictions for any type of offense, and felony convictions one year after discharge than those who did not complete treatment. Rates of arrest were 42% lower, rates of convictions 50% lower, and rates of felony conviction 80% lower.¹

* Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.



Supplement Security Income Recipients Who Completed Chemical Dependency Treatment Had Lower Medical, Psychiatric, and Nursing Home-Related Costs than Those Who Did Not Complete Treatment.*

Source of Costs ¹	Treatment Completers	Treatment Non-Completers
Medical Costs	-\$380	-\$292
Mental Health Costs		
<i>State Hospital Costs</i>	-\$56	-\$46
<i>Community Psychiatric Hospital Costs</i>	-\$33	-\$11
Nursing Home Costs	-\$65	-\$53

Source: Estee, S., & Nordland, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*.

In a study of over 7,000 Supplemental Security Income (SSI) recipients who entered chemical dependency treatment, those who completed treatment had lower monthly medical, psychiatric, and nursing home costs, and hence higher monthly cost offsets than those who did not. Medical care expenses for SSI recipients who completed treatment were \$380 lower than the cost of medical care for those who needed chemical dependency treatment but remained untreated. SSI recipients who did not complete treatment also had lower costs, but by only \$292, or 22.4% less.²

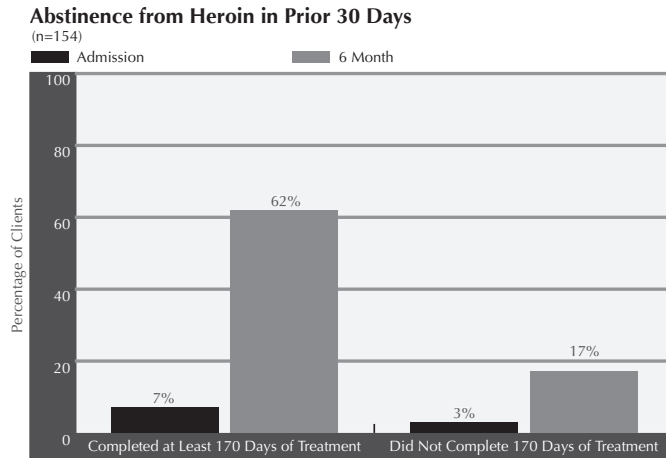
* Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

¹ Costs represent the adjusted average monthly per person difference in costs for SSI recipients receiving chemical dependency treatment compared to costs for those who needed treatment but did not get it.

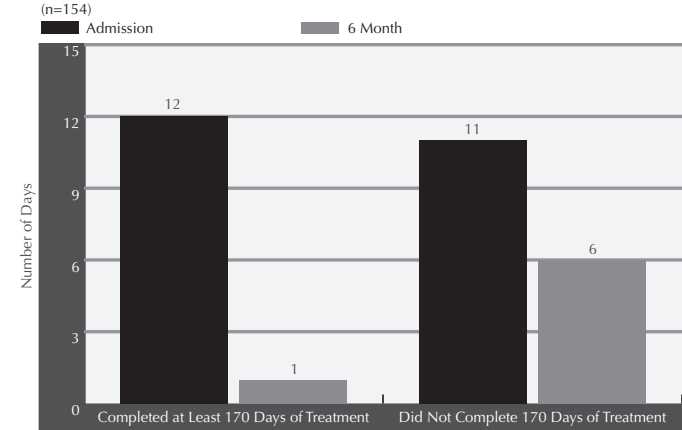
² Estee, S., & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Remaining in Treatment Results in Improved Outcomes Among Patients Receiving Methadone Treatment.

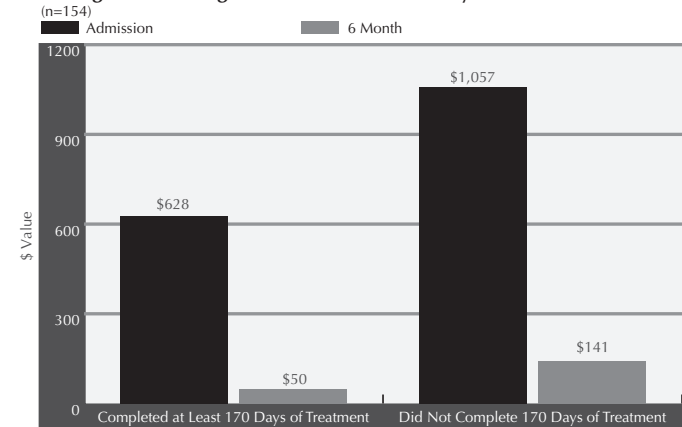
A 2001 study of 154 patients admitted to methadone treatment found that at a six-month follow-up, those who completed at least 170 days of treatment reported substantially higher rates of abstinence from heroin use, fewer days of illegal activity, and substantial decreases in money obtained through illegal activity.



of Days Engaging in Illegal Activity in Prior 30 Days

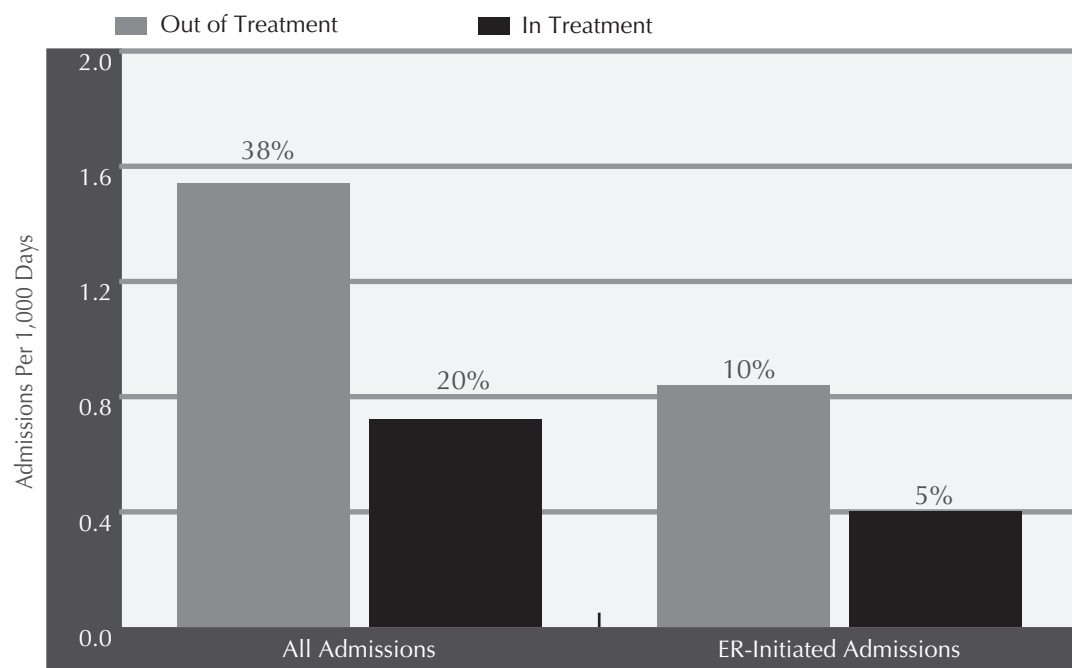


Average \$ from Illegal Sources in Prior 30 Days





Opiate Substitution Treatment Patients are Less Likely to Be Admitted to Hospitals While in Treatment.



Source: Luchansky, B., et al. *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State*. Manuscript being prepared for publication, 2003.

A recent study conducted for the Division of Alcohol and Substance Abuse reported that publicly funded opiate substitution treatment patients were significantly more likely to be admitted to a hospital while they were out of treatment as compared to when they were in treatment. Patients in treatment were 33% less likely to experience a hospital admission than those who left treatment. Most of the hospital admissions came through either the emergency room (56%) or through an urgent care facility (21%). Such acute care services are among the most costly. Medicaid or Medicare paid for 82% of these hospital admissions; only 15% were paid by a private payer.¹ Thus, retention in opiate substitution treatment results in better health for patients, and lower costs to the public.

¹ Luchansky, B., et al. *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State*. Manuscript being prepared for publication. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2003.

Longer Retention in Opiate Substitution Treatment is Associated with Higher Methadone Dose.



	Average Peak Methadone	Average Number of Days in Treatment
Opiate Substitution Treatment Program #1	109 mg/day	284.2
Opiate Substitution Treatment Program #2	83.1 mg/day	193.5

Source: Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Longer retention in opiate substitution treatment is associated with better outcomes: less crime and involvement with the criminal justice system, fewer medical hospitalizations and emergency room visits, lower medical costs, fewer psychiatric hospitalizations, and less reliance on public assistance.

A 2003 study of 135 individuals admitted to two Washington State opiate substitution treatment programs found a close association between average peak methadone dose and average number of days in treatment. Patients in the programs where average peak dose was 109 mg/day remained in treatment an average of 90.7 days longer than those in the program where average peak dose was 83.1 mg/day, a difference of 46.8%. In addition, it was found that patients whose peak methadone dose was less than 75 mg/day were significantly more likely to leave treatment prior to 170 days. The mean peak methadone dose for patients who left treatment prior to 170 days was 78.0 mg/day, compared with a peak dose of 104.6 mg/day for those who remained in treatment at least 170 days.¹

¹ Source: Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

The Future: Policy Issues Confronting Washington State

ISSUES

Alcoholism as a
Chronic Disease

Criminal
Justice

Opiate Substitution
Treatment

Substance Abuse
and Aging

The Future: Policy Issues Confronting Washington State

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Alcoholism as a
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Alcohol consumption in Washington State is at its lowest point in more than two decades. At the same time, chronic drinking rates are at the highest point in more than a decade, as are deaths due to chronic liver disease and cirrhosis. Alcohol abuse and alcoholism remain the number one substance abuse problem in Washington State. Alcoholism bears strong similarities to other chronic health problems such as asthma, diabetes, and high blood pressure.

Per capita alcohol consumption, both in Washington State and the nation, has been dropping steadily since 1980. In Washington State, most of that reduction has been in the consumption of hard liquor.¹ Yet at the same time, chronic drinking rates among Washington State adults appear to be on the rise, and the state has had a consistently higher alcohol-induced death rate than the nation. Deaths due to chronic liver disease and cirrhosis, closely associated with long-term alcohol use, are at their highest point in a decade. The total social and economic costs of alcohol abuse and alcoholism in the United States, estimated at \$184.6 billion, are approximately 50% greater than costs related to abuse of all illicit drugs combined.²

Shorter-Term Problems

Problems associated with alcohol use can be divided, although not cleanly, into those associated with shorter-term and longer-term, or chronic, use. Alcohol abuse – either short-term, intermittent, or binge drinking – is linked with deaths from traffic crashes, falls, fires, and drowning. It is also associated with homicide, suicide, domestic violence, family disruption, and child abuse.³ Binge drinking is also directly related to alcohol poisoning and blackouts. Intermittent use during pregnancy is associated with fetal and infant deaths, low birth weight births, and fetal alcohol syndrome and fetal alcohol effects. Light and moderate alcohol use is associated with 60% of alcohol-related absenteeism, lower worker productivity, and workplace accidents.⁴

Alcoholism as a Chronic Disease

Among young people, alcohol use is also associated with negative academic performance. Students who drink are more likely to have lower grades, cut classes, become truant, and are much more likely to drop out of school. Studies indicate that alcohol-dependent teens manifest impaired memory, altered perceptions of spatial relationships, and verbal skill deficiencies. Young people are also more likely to sustain brain damage as a result of alcohol abuse.⁵ According to a recent study published in the *Journal of the American Medical Association*, underage drinkers account for 19.7% of all alcohol consumed in the United States.⁶

Alcoholism – Associated Medical Problems

Of the nearly 14 million Americans who experience serious problems because of their drinking, some eight million (nearly 60%) suffer from alcoholism, a chronic disease, characterized both by addiction and association with a long list of medical problems affecting virtually every organ system in the body. These alcohol-related problems include:

- High blood pressure (hypertension);
- Large red blood cell anemia;
- Decreased production and efficiency of white cells;
- Decreased production of clotting factors and platelets;
- Heart rhythm irregularities (arrhythmias);
- Heart muscle disorders (cardiomyopathy);
- Heart attacks;
- Stroke;
- Cancers of the mouth, pharynx, larynx, and esophagus;
- Breast cancer;

- Ulcers and gastritis;
- Gastro-esophageal hemorrhage;
- Impaired immune system, leading to increased susceptibility to infections, including pneumonia, tuberculosis, and septicemia;
- Cirrhosis;
- Acute and chronic inflammation of the pancreas;
- Worsening symptoms of mental illness and interference with treatment;
- Compromised sexual function; and
- Reduced bone density and increasing risk of fractures.

Alcohol is an addictive drug. Over time, its use can lead to craving, increased tolerance, and impaired control. As this occurs, medical complications increase, as individuals must access treatment both for the associated medical conditions and their underlying cause.

Alcoholism as a Chronic Disease

A chronic disease is one that continues over a long period of time, progressing either consistently or intermittently. It often can be managed, and is likely to worsen without treatment. The causes of chronic disease can be complex, triggered in different ways, and include hereditary factors. The course of chronic diseases may be unpredictable. Treatment may require that patients change their behavior, and some patients may relapse more frequently than others.

This description closely fits alcoholism. It also describes other chronic diseases such as asthma, diabetes, and high blood pressure.

The resemblances among these chronic diseases are striking. Genetics play a heavy role in each, causing individuals to become vulnerable. In the case of alcoholism, studies suggest that genetic factors account for 50-60% of the propensity toward the disease. People who are at genetic risk for asthma, diabetes, high blood pressure, and alcoholism can control certain risk factors. Doing so in the case of alcoholism by choosing not to drink may be more difficult than for other diseases, especially among young people, as social encouragement to use alcohol is widespread. Over time, there is strong evidence that drinking by alcoholics negatively impacts brain chemistry, making it increasingly difficult for individuals to control their disease.

As with asthma, diabetes, and high blood pressure, there is no known cure for alcoholism, but there are clear diagnostic criteria, research-based treatment guidelines and protocols, and proven effective patient and family educational interventions. Following treatment, a higher percentage of patients with alcoholism follow treatment regimens faithfully than do those with other chronic diseases. Relapse rates for alcoholism are no higher, and in some cases lower, than for other chronic diseases.

Four Steps Toward Dealing with Alcoholism as a Chronic Disease

1. Prevention

The most effective public health approach to chronic diseases is to prevent them before they make their appearance. With the aid of the Division of Alcohol and Substance Abuse (DASA) and the Western Center for the Application of Prevention Technology, schools and community coalitions across Washington are applying evidenced-based practices to the prevention of alcohol abuse and alcoholism among youth. These range from *universal* prevention approaches aimed at entire populations –





whether in schools or communities, to *selective* prevention targeting those who are at high-risk for alcohol abuse, to *indicated* approaches aimed at those for whom abuse has already started.

In Washington State, the prevention field makes use of the risk-and-protective framework pioneered by University of Washington researchers Drs. David Hawkins and Richard Catalano. By isolating those factors that put young people at particular risk for substance abuse, and those factors that are protective, the framework enables schools and communities to develop a chain of inference in choosing prevention applications likely to result in reduced levels of alcohol use.

Other factors affecting youth use of alcohol and the long-term progression to alcoholism include price, availability, and advertising, which makes drinking appear glamorous and appealing. New approaches to youth alcohol consumption, such as social marketing, which has been pioneered at Western Washington University, show promise in changing the culture of drinking on college and university campuses, weakening the links between early abuse and the progression to a chronic disease condition.

2. Brief Interventions

Since the progression from alcohol abuse to the chronic disease of alcoholism may be slow, individuals may not be fully aware of their symptoms. It is sometimes possible to intervene opportunistically in the life of the alcohol abuser and engage awareness of the need to limit consumption, or eliminate it all together, without the need for substance abuse treatment.

Dr. Larry Gentilello conducted a study of patients admitted to the trauma center at Harborview Medical Center. Of 2,524 patients screened, 1,153 (46%) were found to have signs indicative of an alcohol-related problem. Patients were assigned to two groups: those receiving no follow-up for their alcohol-related problem, and those who received

a single motivational interview with a psychologist trained in the use of brief interventions. A focus was placed on the patient's assuming personal responsibility for reducing drinking to decrease his or her level of risk. A menu of strategies was provided, including a list of treatment resources and self-help groups in the community. At the 12-month follow-up, those who received the intervention decreased alcohol consumption by an average of 21.8 alcoholic drinks per week. At the three-year follow-up, they experienced a 47% reduction in injuries requiring emergency department or trauma center admission, and a 48% reduction in injuries requiring hospital admission.⁷

Similar opportunities for brief interventions exist in regular visits to doctors' offices. It is estimated, however, that fewer than 30% of primary care physicians screen their patients for health problems related to their use of alcohol. Opportunities for brief interventions also exist in the workplace, especially through the use of Employee Assistance Programs.

3. Reducing Stigma

"Changing the Conversation", the federal Center of Substance Abuse Treatment's "National Treatment Plan Initiative", singled out stigma as a powerful, shame-based mark of disgrace and reproach that impedes treatment and recovery. Stigma prevents widespread recognition of alcoholism as a chronic disease. Because of the stigma attached to it, physicians, insurance companies, and even state governments fail to acknowledge alcoholism as a medical problem. And stigma often prevents individuals from seeking treatment for their addiction.

It should be noted that the stigma attached to alcoholism has some subtle differences from that attached to drug addiction. Society often views drug addiction as first and foremost a criminal justice problem, and hence, those addicted are viewed as criminals, thus hampering both assessment



of, and treatment for, the condition. In contrast, alcohol use is legal, widespread, and often socially encouraged. Those afflicted with a chronic disease related to its use may be ostracized as “weak-willed” or “lacking in self-control”.

“Changing the Conversation” proposes a four-step approach to reduce stigma and change attitudes about people at risk for, in need of treatment for, or in recovery from alcoholism (and drug addiction):

- Conduct science-based marketing research (i.e., polling surveys, focus groups, etc.) to provide the basis for a social marketing plan;
- Based on the results of the research, implement a social marketing plan designed to change knowledge, attitudes, beliefs, and behavior of individuals and institutions to reduce stigma and its negative consequences;
- Facilities and support grassroots efforts to build the capacity of the recovery community to participate in the public dialogue about addiction, treatment, and recovery;
- Promote the reduction of stigma and discrimination against people in treatment or in recovery by encouraging respect for their rights in a manner similar to that afforded to people who suffer from, and overcome, other chronic diseases.

4. Increasing Availability of Treatment

There is a huge gap between those who both qualify for treatment for alcoholism and are in need of it, and those who actually receive it. Alcoholism among those with private health insurance that would cover treatment often goes

untreated, as more than two-thirds of physicians do not offer appropriate screening and referral. Because of stigma, individuals may deny that they suffer from this debilitating disease. Institutional barriers exist, such as RCW 48.20.272, which allows insurance companies to escape liability for losses sustained in consequence of an individual’s intoxication. This law, built on stigma, may cause hospital emergency rooms and physicians to be reluctant about referring patients for chemical dependency assessments or to conduct brief interventions. Individuals may be reluctant to use Employee Assistance Programs for fear that confidentiality may be compromised.

Alcohol is consistently cited as the primary drug of abuse in a large plurality (48%) of adult admissions to DASA-funded treatment. But the treatment gap is such that some 75.3% of adults in need of, and who qualify for, DASA-funded treatment (for all drugs, including alcohol) do not receive it. Such levels of unmet need in dealing with any other chronic disease condition would like be considered medical malpractice.

As the treatment providers become increasingly effective in retaining patients until they complete their treatment plans, the number of admissions to publicly funded treatment is likely to decline. DASA-funded admissions to treatment for alcoholism reached their peak in SFY 1999 (16,514) and have been declining steadily since (14,758 in SFY 2002). Waiting lists for treatment under the Alcohol and Drug Abuse Treatment and Support Act have tripled since 1991, and have accelerated greatly in the past three years. A new commitment to the funding of quality alcoholism treatment services will be necessary if Washington State is to realize the promise of our ability to turn the tide against the chronic disease that afflicts so many of our citizens.

¹ National Institute on Alcohol Abuse and Alcoholism, *Per Capita Ethanol Consumption for States, Census Regions, and the United States, 1970-1999*.

² National Institute on Alcohol Abuse and Alcoholism, *10th Special Report to Congress on Alcohol and Health*. Washington, DC: Department of Health and Human Services, 2000.

³ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-4. Washington, DC: 2000.

⁴ Mangione, T., Howland, J., and Lee, M., *New Perspectives for Workplace Alcohol Strategies: Results from a Corporate Drinking Study*. Washington, DC: National Institute on Alcohol Abuse and Alcoholism, 1998.

⁵ Center for Substance Abuse Prevention, “Underage Drinking and Academic Performance,” *Prevention Alert*, Vol. 5 No. 12, September 27, 2002.

⁶ Foster, S. et. al., “Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking,” *Journal of the American Medical Association*, Vol. 289, No. 8, February 26, 2003.

⁷ Gentilello, L., et al., “Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence,” *Annals of Surgery* Vol. 230, No. 4, July 1999.

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Criminal Justice

Substance-abusing offenders comprise the majority of Washington's prison population. The costs to the state in incarcerating these offenders have increased radically in the past two decades. New criminal justice reforms, including a strong commitment to treatment, hold out the promised of reduced incarceration, recidivism, and greater public health and safety.

The last two decades have witnessed substantial increases in the number of drug-related offense cases in both Washington State and across the nation. Coupled with ever-more punitive state and federal sanctions for drug possession, manufacturing, and distribution, these increases have contributed significantly to the problems faced by already overtaxed law enforcement agencies and courts, and overcrowded jails and prisons. Additionally, there have been significant increases in the number of substance-abusing offenders serving time for non-drug-related offenses.

Since the July 1, 1984, implementation of the Sentencing Reform Act of 1981 (SRA), the Washington State Legislature has amended adult felony sentencing law in every legislative session except 1985. From 1985-2002, the number of drug offenders in state prisons increased well over 1,800%, from 173 to 3,334. Of the 16,014 offenders in state prisons at the end of State Fiscal Year (SFY) 2002, 20.8% were drug offenders (compared to 2.6% at the end of SFY 1985).

While drug offenders make up an ever-increasing percentage of the state's prison population, they are not the only offenders in need of substance abuse treatment. The Department of Corrections (DOC) estimates that 60-80% of inmates are in need of substance abuse treatment. Only approximately 18% of inmates received such treatment in SFY 2001.¹

Without appropriate treatment, substance-abusing offenders, once released, are more likely to re-offend and, therefore, be returned to prison. The operational costs of incarcerating

these offenders, and the costs of servicing the debt associated with the capital expansion needed to create beds for the continually increasing inmate population, are overwhelming. The operational costs alone of incarcerating drug offenders has increased from \$3.0 million in SFY 1985 to \$84.8 million in SFY 2002 – an increase of nearly 3,000% since the implementation of the SRA. This does not include operational costs for other substance-abusing offenders; nor does it include any capital expenditures.

Additionally, none of the above takes into account the costs to victims, or to law enforcement, courts, and local jails in dealing with substance-abusing offenders. Adult and juvenile arrests for drug offenses alone have increased 287% since 1985, while adult felony superior court filings for drug offenses have increased by 406% over the same period.

It has become increasingly clear to criminal justice personnel and policymakers that the traditional means of adjudicating and punishing non-violent drug-abusing offenders, while expensive, has not been effective. It has done little to reduce criminal recidivism, curtail drug use, or enhance public safety.

The Effectiveness of Treatment

As the cost of incarcerating offenders has risen, there has been a growing awareness of the effectiveness of substance abuse treatment in reducing recidivism and costs. A 2002 study of patients receiving publicly funded treatment in Washington State examined arrest records before and after treatment. The study found:

- A 21% decline in the number of patients arrested following treatment;
- A 33% decline in the number of arrests for felony offenses following treatment; and

- Reduced risk of felony arrests for patients that complete treatment and for those with longer stays.²

A review of all drug court evaluation studies in the United States undertaken by the Washington State Institute for Public Policy concluded that drug courts save nearly three dollars for every dollar of taxpayer expenditure when factoring in victim costs, and they reduce recidivism (compared to standard courts) from 45.8% to 39.7%, representing a decrease of 13.3%.³ Providing treatment to substance-abusing offenders benefits offenders, the criminal justice system, taxpayers, and communities.

Drug Courts

The strategy behind drug courts is to use the coercive power of the criminal justice system to force substance abusing offenders to undergo substance abuse treatment. By treating substance abuse problems, criminal recidivism and the associated criminal justice costs, as well as the greater social and economic costs associated with substance abuse, can be reduced.

The first drug courts began operation in Washington State in 1994. Adult drug courts currently operate in 12 counties – Clallam, Clark, Cowlitz, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom and Yakima – with additional courts being planned in Benton-Franklin and Mason Counties. There are also three tribal drug courts – Makah, Spokane and Yakama – with four more – Lummi, Nooksack, Shoalwater, and Suquamish – being planned.

In addition to adult and tribal drug courts, there are juvenile, youth-at-risk, misdemeanor, dependency, and family treatment courts, all using the drug court model. King County operates a mental health court that utilizes the drug court model to serve mentally ill offenders. Overall, Washington has 30 operating non-tribal and tribal drug courts,

two mental health courts and 14 drug courts in the planning stages. Additionally, drug courts will be a primary mechanism for providing judicially supervised treatment under the new criminal justice reform measures.

Adult Offenders

Drug Offender Sentencing Reform

With bipartisan support, Second Substitute House Bill 2338 was passed by the 2002 Legislature and signed into law by Governor Locke. The law effects major changes in drug offender sentencing in Washington State. Key provisions of the new law include:

- Establishing the Criminal Justice Treatment Account (CJTA), funded out of savings to the Department of Corrections by reducing sentences for certain drug offenders;
- Utilizing savings for treatment and limited treatment support services;
- Establishing work groups to develop a methodology for calculating the savings; formulas and grant processes for distributing the funds to the counties; and county plans for submission to the formula and grant panels;
- Establishing a drug offender sentencing grid and a review committee;
- Setting minimum standards for the participation of offenders in drug courts; and
- Authorizing studies of the effectiveness of the new sentencing grid and drug courts.

Under the new statute, resultant prison bed savings are to be calculated for each biennium, beginning with the 2003-2005 Biennium. The amount of the calculated savings is to be





transferred from the General Fund to the CJTA (75% of the savings, up to \$8,250,000 per fiscal year) and the Violence Reduction and Drug Enforcement Account (VRDE) (25% of the savings). The money transferred to the CJTA will be distributed by the Division of Alcohol and Substance Abuse to counties (70% using a funding formula, and 30% through a grant program) for use in providing substance abuse treatment for offenders at the local level. Funds transferred to VRDE will be used to provide substance abuse treatment for offenders confined in state prisons.

The table below shows the official average monthly population bed impact estimates and the estimated dollar savings for the 2003-2005 Biennium.

Of the total estimated savings of \$11,945,942 for the Biennium, 75% (\$8,959,456) will be transferred to the CJTA for distribution to the counties. It is estimated that approximately 4,000 offenders will receive treatment as a result.

Since the statute became effective, continuous progress has been made toward implementation of its provisions. All of the work groups and committees established by the bill have been formed and have been working toward their assigned goals. The work group charged with developing a methodology for calculating the biennial savings under the bill has completed that task, as demonstrated by the estimated savings shown below. The CJTA Panel has established a formula – utilizing combination of the percentage of at-risk

adults (age 18 to 54) in each county at or below 200% of the Federal Poverty Level, the number of certain felony and misdemeanor filings in each county, and the percentage of adults in each county at or below 200% of the Federal Poverty Level who are in need of treatment – to distribute 70% of the CJTA funds. The Panel has also established criteria for distributing the other 30% of the money via grants, and is currently in the process of reviewing the grant applications to determine which counties will receive grant funds.

Drug Offender Sentencing Alternative

The Drug Offender Sentencing Alternative (DOSA) is an adult felony sentencing alternative aimed at providing substance abuse treatment for certain offenders. An offender is eligible for DOSA if:

- (s)he is convicted of a felony that carries a standard range of more than one year;
- the felony is not a sex offense or a violent offense and does not involve a weapon enhancement;
- the offender has no prior convictions for a sex offense or a violent offense, and is not subject to a deportation detainer or order; and
- the offense is a drug offense, and the quantity of the drug involved is small.

	<i>Fiscal Year</i>				
	<i>FY03</i>	<i>FY04</i>	<i>FY05</i>	<i>FY06</i>	<i>FY07</i>
<i>Estimated Prison Bed Savings</i>	-18	-148	-321	-452	-529
<i>Cost Per Prison Bed Per Year</i>		\$25,447	\$25,447		
<i>Estimated Dollar Savings</i>		\$3,765,808	\$8,180,133		
<i>Total Savings for the Biennium</i>		\$11,945,942			



If an eligible offender is sentenced under DOSA, the offender receives a prison term that is one-half of the midpoint of the standard sentence range in length, community custody for the remainder, and must meet various other conditions. While the offender is serving the term of confinement, (s)he undergoes a comprehensive substance abuse assessment and receives appropriate treatment. There were 2,087 sentences under DOSA in SFY 2002.

Department of Corrections

While offenders sentenced under DOSA are given priority for substance abuse treatment services in DOC, they are not the only offenders who receive treatment. Any offender under the supervision of DOC assessed as having substance abuse problems may be eligible for treatment. Substance abuse treatment services are provided to about 6,000 offenders annually, at 33 locations throughout the state. Services offered include long-term residential (in the form of modified therapeutic communities), intensive outpatient, and standard outpatient treatment. Additionally, specialized dual-diagnosis, maintenance, and gender-specific treatment tracks are being developed. Offenders in correctional facilities or under supervision in the community are both eligible for treatment.

City and County Jails

Many of the local jails in Washington State provide some form of substance abuse treatment for incarcerated offenders. Based upon a 1999 survey of the 37 county jails and 20 city jails operating: 13 county jails offered drug and alcohol education or awareness, 16 county jails and three city jails provided for non-medical detoxification, 35 county jails and seven city jails offered substance abuse self-help group programs, and 12 county jails provided additional substance abuse treatment⁴

Juvenile Offenders

Juvenile Rehabilitation Administration

The Juvenile Rehabilitation Administration (JRA) estimates that approximately 79% of youth entering its facilities have substance abuse-related problems. JRA has adopted an integrated service model to develop and implement substance abuse programming, with a primary goal of reducing recidivism through the early identification and treatment of chemical abuse. Among the substance abuse services provided by JRA are: screening, assessment, and diagnosis; substance abuse education; inpatient and intensive outpatient treatment at several facilities, recovery house services at one facility; and transitional and aftercare treatment services. Approximately 56 youth are served each month.

Chemical Dependency Disposition Alternative

The Chemical Dependency Disposition Alternative (CDDA) provides juvenile courts with a sentencing option for substance-abusing juvenile offenders, allowing judges to order youth into treatment instead of confinement. A juvenile is eligible for CDDA if (s)he has committed a specific type of offense which is subject to a standard range disposition of local sanctions or 15-36 weeks of confinement, and has a substance abuse problem. Under CDDA, the court imposes the standard range sentence or raises it, suspends the disposition, places the offender on community supervision for up to one year, orders outpatient and/or inpatient substance abuse treatment, and may impose up to 30 days of confinement, 150 hours of community restitution, and payment of legal financial obligations and restitution.

CDDA represents a collaboration between the Juvenile Rehabilitation Administration (JRA), Medical Assistance Administration, DASA, local juvenile courts, the University of Washington, and county alcohol/drug coordinators.



According to JRA, 516 juvenile received chemical dependency treatment under CDDA in SFY 2002.

Local Juvenile Detention Facilities

Most local juvenile detention facilities in Washington State offer some form of substance abuse treatment. Based upon a

1999 survey of local juvenile detention facilities in Washington State, 19 of the 21 operating facilities offered substance abuse treatment: 11 offered substance abuse treatment under the CDDA program; 17 offered substance abuse self-help group programs; nine facilities had non-CDDA certified outpatient treatment; and 12 facilities provided additional forms of substance abuse.⁵

¹ Washington State Department of Corrections – Chemical Dependency Program Overview, March 2001.

² Washington State Department of Social and Health Services, Research & Data Analysis Division. *Fact Sheet 4.42*. Olympia, WA: March 2002.

³ Washington State Institute for Public Policy, *Washington State's Drug Courts for Adult Defendants: Outcome Evaluation and Cost-Benefit Analysis*. Olympia, WA: March 2003.

⁴ Vukich, E. and Daniels, K., *City and County Jails in the State of Washington: The Washington State Master Capacity Plan Snapshot Report*. Olympia, WA: Washington Association of Sheriffs and Police Chiefs, Washington State Department of Corrections, Washington State Sentencing Guidelines Commission, 2000.

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OPIATE SUBSTITUTION TREATMENT

Opiate substitution treatment is scientifically proven to be effective in the treatment of heroin addiction, resulting in reductions in criminal behavior, lower medical and psychiatric costs, improved health, and lower rates of illicit drug use. A new medication for opioid maintenance, buprenorphine, can be dispensed by physicians in their offices, and shows promise as another treatment option.

The White House Office of National Drug Control Policy estimates there may be as many as 980,000 users of heroin nationwide.¹ It is estimated that almost 30,000 Washington State residents have been dependent upon opiates (primarily heroin) during their lifetimes.² Most do not receive treatment. The National Institutes of Health estimate the financial costs of untreated heroin addiction to individuals, families, and society in the U.S. at approximately \$20 billion each year.³

People with chronic heroin addiction pose a significant public health risk to our communities. As a large majority are injection drug users (IDUs), heroin addicts are more likely to contract and spread HIV and hepatitis B and C. The federal Centers for Disease Control and Prevention estimate that IDUs (most of whom are heroin users), their sexual partners, and their offspring account for approximately 35% of new HIV infections each year.⁴ Chronic heroin users are more likely to engage in criminal activity, and are more likely to place increased strain upon public resources in welfare costs, emergency room and hospital admissions, and psychiatric hospitalizations.

Scientifically Proven

Methadone and other forms of opiate substitution have been shown scientifically to work effectively in the treatment of heroin addiction. In its 2000 National Drug Control Strategy, the White House Office of National Drug Control Policy called methadone therapy “one of the longest established,

most thoroughly evaluated forms of drug treatment.”⁵ A Consensus Panel convened by the National Institutes of Health (NIH) in 1997 concluded, “Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity.” A 1998 review by the General Accounting Office found that methadone therapy helps keep more than 179,000 addicts off heroin, off welfare, and on the tax rolls as law abiding, productive citizens.⁶

Seattle-King County – A Success Story

The experience of Seattle-King County is particularly instructive. From 1990 to 1998, the rate of heroin-related deaths in King County grew more than 170%. In 1998, there were more unintentional opiate overdose deaths in King County (143) than traffic deaths (119).⁷

Faced with an epidemic, city and county government undertook a coordinated response to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. The County also provided preventive and limited substance-abuse treatment services in the local criminal justice system, and expanded the availability of drug-free housing for individuals in recovery.

The result is that heroin-related deaths in King County declined dramatically, by 57%, to 61 deaths in 2001. The rate of heroin-related deaths fell from 8.8 per 100,000 people in 1998 to 3.5 per 100,000 in 2001. Emergency room mentions of heroin similarly declined, from 78 per 100,000 people in July-December 1997, to 38 in January-June 2001, representing a 51% decrease. Recently, however, new treatment admissions have also declined, probably because effective treatment is resulting in longer treatment stays, and correspondingly fewer open treatment slots.⁸ There is still a waiting list of 500-600 people in King County at the Seattle

Needle Exchange who have requested treatment, but are unable to access it because of limited treatment capacity and sources of funding.⁹

The Situation in Washington State Today

Opiate substitution treatment clinics have been operating in Washington State for more than 25 years. As of December 2002, there are 13 opiate substitution treatment clinics operating in five counties. Six fixed locations and one mobile clinic are in King County, two of which serve only private-pay patients. In addition, there is a pilot program at Harborview Medical Center through which physicians provide opiate substitution treatment to clinically stable patients. Pierce County has two clinics (now operating as a single program), and Spokane and Yakima Counties each have one. A new clinic was opened in Thurston County in September 2002. Clark County contracts with an opiate substitution treatment program in Portland, Oregon to serve its residents. The Veterans Administration contracts with two clinics (in Spokane and Yakima) to provide services and, additionally, operates two clinics itself in the Puget Sound region. Hearings regarding placement of new clinics have been held in Clark, Pierce, and Snohomish Counties. One federally-recognized Tribe – the Stillaquamish – is also in the process of setting up a new opiate substitution clinic.

As of January 1, 2002, 3,200 individuals were receiving opiate substitution treatment for heroin addiction, an increase of 5.3% over the same date in 2001. Of these, 1,714 (53.6%) were publicly funded. There are waiting lists, sometimes six months or longer, for the publicly funded slots at each of the operating clinics, preventing treatment at that critical juncture when addicted individuals are prepared to access it.

Patient Profile

RCW 70.96A.420(4) requires DASA to provide an “outcome analysis” of programs providing opiate substitution treatment. In fact, DASA has been studying opiate substitution treatment for almost a decade and has established appropriate performance measures for evaluating cost effectiveness and efficacy.

The 2002 Report to the Legislature, *Determining the Value of Opiate Substitution Treatment*, studied outcomes of 962 patients discharged from treatment in the first nine months of 2001. Six hundred of the patients were publicly funded, while 362 had their treatment privately paid.

Among publicly funded patients, 52% were female, and 68% were white (non-Hispanic). Median age was 41 (with a range of 15-69), with 40% having children under age 18. Some 95% of publicly funded patients reported heroin as their primary substance of abuse; all but 2% were also abusing other substances upon entry into treatment. Median of first use was 21 (with the youngest being age ten), indicating that the average methadone patient had been using heroin for 20 years prior to current entry into treatment. Other studies indicate that most patients are likely to have had multiple prior entries into drug-free treatment for their addiction.

Evaluating Cost-Effectiveness and Efficacy

The Report to the Legislature undertook to answer two questions:

- Does opiate substitution treatment contribute to reducing the negative consequences of opiate addiction – crime, health problems, and reliance on welfare?





- Does opiate substitution treatment support the Department of Social and Health Services' mission to assist clients in maintaining safe, secure, self-sufficient, and healthy lives?

The results of the 2002 study are compelling. Among the 600 publicly funded clients discharged from treatment, the following outcomes were achieved:

- Property crimes were reduced by 64%;
- Emergency room visits decreased by 51%;
- Overall arrest rates declined by 63%;
- Drug offense arrests dropped by 81%;
- Medical hospital admissions were reduced by 48%;
- Utilization of major health care services were lowered by 37%;
- Psychiatric hospitalization declined by 50%; and
- Employment increased by 22%.¹⁰

Treatment Works

At admission for opiate substitution treatment, 82% of publicly funded patients in treatment less than one year used heroin at least daily. By discharge, only 15% were daily users, representing a decline of 82%. Daily heroin use for publicly funded patients in treatment one year or longer declined from 75% to 8% at discharge, representing a reduction of 89%.

In a study undertaken by Dr. Molly Carney and others at the Alcohol and Drug Abuse Institute, University of Washington, of those admitted to opiate substitution treatment, 55.0% were abstinent from heroin during the 30 days prior

to the six-month follow-up, and 69.5% were abstinent from heroin during the 30 days prior to the 12-month followup. Changes were found to be directly related to length-of-stay in treatment (longer courses of treatment resulting in better outcomes.)¹¹

An interesting result of Dr. Carney's study, which has also been seen in other studies, is that it focuses attention on the relationship between methadone dosing and treatment retention. The study examined two programs, with different mean peak doses: the first with a peak dose of 109.1 mg/day, the second with a peak dose of 83.1 mg/day. In the first program, average length of stay was 284.2 days, almost 50% greater than in the second, at 193.5 days. At 180 days following admission, 80.9% of participants in the first program were retained, while in the second, less than half (47.8%) remained. More research is needed to establish best practices in dosing levels specific to patients now being treated in Washington State clinics.

Challenges Ahead

Better treatment outcomes for opiate substitution patients are clearly tied to longer treatment retention. This poses a special challenge for providers and for the Division of Alcohol and Substance Abuse, as efforts to retain patients in treatment longer mean that fewer patients are able to access treatment at all. Without increased capacity and funding, waiting lists continue to get longer. Not being able to provide treatment in a timely fashion to those who request it means a continuation of crime and criminal justice costs, higher emergency room and hospital admissions, and continued HIV and hepatitis B and C disease spread.

One promising approach to freeing up space in existing clinics is to find ways to serve stable, long-term patients who no longer require extensive monitoring and counseling services in physician-based programs. Such a program is currently



being piloted between Evergreen Treatment Services (ETS) and Harborview Medical Center, and shows great sign of promise. Beginning in January 2000, 30 patients who were clinically stable for at least one year were transferred to Harborview (ten in January, and the rest during the summer of 2000). They had each been receiving opiate substitution treatment for between two and 22 years, with a mean of ten years. Of these patients, 27 currently remain in the program after a year or more; one transferred to an opiate substitution treatment program in another state; one transferred back to the ETS mobile van program; and one died (cause of death was unrelated to drug use). None was discharged from treatment because of rule violations related to drug use.¹²

A second approach is to find ways to reduce demand for methadone maintenance treatment by intervening in the lives of patients before addiction has already become chronic and such treatment is needed. A new medication, buprenorphine, has recently been approved for dispensing through physician offices, once physicians have received the necessary training. Buprenorphine has shown effectiveness in studies conducted in other countries, provided appropriate counseling is also available as part of the treatment regimen. It is likely that such an approach, funded through traditional insurance mechanisms and publicly funded medical services plans such as Medicaid, may help to mitigate existing demand for treatment.

¹ Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, 16. Washington, DC: Office of the White House, 2000.

² Kohlenberg, E., Yette, R., and Mack, C., *Needs Assessment Data Project Report: Division of Alcohol and Substance Abuse, Fiscal Year 1990*. Olympia, WA: Department of Social and Health Service, Office of Research and Data Analysis, 1992.

³ National Institutes of Health, *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*, November 17-19, 1997.

⁴ Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*. Atlanta, GA: U.S. Department of Social and Health Services, Public Health Service, 1998.

⁵ Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, 57. Washington, DC: Office of the White House, 2000.

⁶ Ibid.

⁷ Solet, D., Hagan, H., Nakagawara, J., Plough, A., and Ball, J. "Unintentional Opiate Overdose Deaths – King County, 1990-1999. *Morbidity and Mortality Weekly*, 49:29, pp. 636-640.

⁸ Banta-Green, C., et al. "Recent Drug Abuse Trends in the Seattle-King County Area," *Epidemiologic Trends in Drug Abuse*, June 2002.

⁹ See Public Health – Seattle & King County, *Heroin Task Force Report: Confronting the Problem of Heroin Abuse in Seattle and King County*, August 2001.

¹⁰ Baxter, B., and D. Albert. *Report to the Legislature: Determining the Value of Opiate Substitution Treatment, RCW 70.96A.420(4)*. Olympia, WA: Washington State Division of Alcohol and Substance Abuse, 2002.

¹¹ Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample*. Seattle, WA: University of Washington, Alcohol & Drug Abuse Institute, 2003.

¹² Joe Merrill, Harborview Medical Center, Personal communications, October 24, 2001, November 4, 2002. See also Merrill, J., "Policy Progress for Physician Treatment of Opiate Addiction," *Journal of General Internal Medicine* 2002, 17:361-368.

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The percentage of Washington State's population over age 65 is increasing rapidly. Abuse of alcohol and prescription drug misuse and abuse are already major problems among older adults, but often go undiagnosed and untreated. New approaches to substance abuse prevention and treatment for this population are required.

The population of the United States and of Washington State is aging. Approximately 35 million people in the United States are 65 or older, accounting for about 12.4% of the total population. It is anticipated that the aging of the “baby-boomer” generation (born between 1946 and 1964) will increase this proportion to 20%, or 70 million people by the year 2030. According to the 2000 U.S. Census, over 12% percent of the population of Washington State is 60 years old and over. Demographic projections suggest the population will become more ethnically and racially diverse, live longer, and face higher health care service and prescription drug costs than ever before. This expected increase in the elderly population has major ramifications. There will be a sizable increase in the proportion of older men and women without family support and with generally lower incomes. And, there is likely to be increased pressure on the health care services and on the demand for social services.

Abuse of alcohol and legal drugs, prescribed and over the counter, is currently a serious health problem among older Americans, affecting up to 17% of adults age 60 and older.¹ It is estimated that the health care impacts of substance abuse among older adults – in hospital, nursing, physician, and home health services – exceeds \$60 billion a year.²

Prescription drug misuse and abuse are prevalent among older adults, not solely because more drugs are prescribed, but because aging affects vulnerability to drugs. Substance abuse-related problems may spiral higher as baby boomers age and experience chronic physical disability, shrinking social networks, and lower standards of living. Forecasts

Substance Abuse and Aging

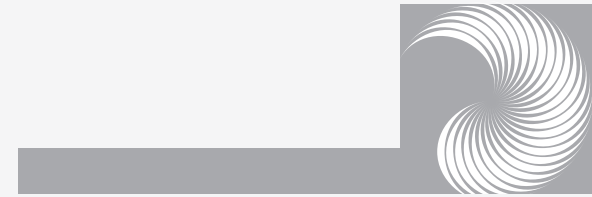
suggest an escalation of the approximately 1.7 million current substance-abusing or dependent adults over age 40 to 4.4 million by 2020.

Yet, even as the number of older adults suffering from these disorders climbs, the situation often goes undiagnosed and untreated, leading to what is called “the invisible epidemic”. Diagnosis is difficult because symptoms of substance abuse in an older individual sometimes mimic symptoms of other medical and behavioral disorders common among this population, such as diabetes, dementia, and depression. However, 6-11% of older patients admitted to hospitals exhibit symptoms of alcoholism.³ For people age 60 and older receiving publicly funded chemically dependency treatment in Washington State, 89% were admitted for alcohol and 6% for heroin addiction, while 1% were admitted for marijuana.

Many older adults who become chemically dependent do so later in life, after retirement, or after their children are grown and moved away. Many begin drinking after the death of a spouse or other close loved ones. Grief, loneliness, isolation, and shame are a few of the factors that make older adults susceptible to the misuse or abuse of alcohol and other drugs.

Even though alcoholism affects a large population of older adults, prescription medication misuse is another common form of drug abuse among the elderly. It is difficult to accurately estimate the extent of prescription drug abuse in this population. Currently, nearly 85% of all persons over 65 take prescription medication. Half of those medications are tranquilizers or sedatives.⁴ Because about 50% of the elderly are light or moderate drinkers, interaction between alcohol and other drugs is likely to become an even more significant problem with the aging of the population.⁵

While older adults, as a group, are often in denial about their need for treatment, and hence are not likely to enter



a treatment program. Once in, they have the highest recovery rate of any age group. However, a shortage of trained geriatricians and other relevant professionals limits awareness and understanding of specific clinical patterns and responses in the elderly.

Given a significant expansion of this group of elderly abusers in the coming decades, more informed and active policy will require new approaches and investment in prevention, treatment, and management strategies specifically tailored for the older population.

¹Office of Applied Studies, Substance Use by Older Adults: Estimates of Future Impact on the Treatment System. Bethesda, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2002.


²National Evaluation Data Services, Substance Abuse Among Aging Adults: A Literature Review. Rockville, MD: Department of Health and Human Services, Center for Substance Abuse Treatment, September 2002.

³Adams, W., et al., "Alcohol Abuse in Elderly Emergency Department Patients," *Journal of the American Geriatric Society* 40(12), 1992, 1236-1240.

⁴Hazelden Foundation, "Older Adults are At Risk for Alcohol and Other Drug Dependency," Newsletter - May 1995

⁵Adams, W., "Interactions Between Alcohol and Other Drugs," in Gurnack, A. (editor), *Older Adults' Misuse of Alcohol, Medicines, and Other Drugs*. New York, NY: Springer Publishing Co. 1997.

Data Sources



DATA SOURCES



Data Sources

Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State – 2003 contains information and data from a wide variety of federal and state government agencies. Given the diverse indicators included in this Report, data sources differ significantly with regard to methodology, sampling and collection procedures, as well as in the reliability and validity of the data. Report users are encouraged to consult the original data sources for more detailed information.

National Sources

Monitoring the Future (MTF) (www.isr.umich.edu/src/mtf)

Conducted by the Institute for Social Research, University of Michigan, and supported by research grants from the National Institute on Drug Abuse, the Monitoring the Future (MTF) project studies changes in the beliefs, attitudes, and behavior of young people in the United States. Surveys have been carried out each year since 1975. Students in the 8th, 10th, and 12th grades complete self-administered, machine-readable questionnaires in their classrooms. Surveys are administered from February to May, invalidating direct comparisons with results from a similar survey – the Washington State Survey of Adolescent Health Behaviors – which is administered in October. Data are used to monitor trends in substance use and abuse among adolescents, and progress toward national education goals for safe, disciplined, and alcohol- and drug-free goals. Results are also used in development of the White House National Drug Control Strategy.

National Institute on Drug Abuse (NIDA) (www.nida.nih.gov/)

The mission of the National Institute on Drug Abuse (NIDA) is to lead the nation in bringing the power of science to bear on drug abuse and addiction. NIDA seeks to accomplish this mission through the strategic support and conduct of research across a broad range of disciplines. NIDA supports over 85% of the world's research on health-related aspects of drug abuse and addiction. NIDA also works to ensure the rapid and effective dissemination and use of results from research to significantly improve drug abuse and addiction prevention, treatment, and policy. NIDA is one of the 19 institutes that comprise the National Institutes of Health (NIH).

National Institute on Alcohol Abuse and Alcoholism (NIAAA) (www.niaaa.nih.gov/)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of 19 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the federal government. NIAAA provides leadership in the national effort to reduce alcohol-related problems by:

- Conducting and supporting research in a wide range of scientific areas including genetics, neuroscience, epidemiology, health risks and benefits of alcohol consumption, prevention, and treatment;
- Coordinating and collaborating with other research institutes and federal programs on alcohol-related issues;
- Collaborating with international, national, state, and local institutions, organizations, agencies, and programs engaged in alcohol-related work; and



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- Translating and disseminating research findings to health care providers, researchers, policymakers, and the public.

NIAAA-supported research and direction are aimed at:

- Removing the stigma associated with the common complex disease of alcoholism;
- Revealing genetic, other biological, and sociocultural origins of variations in individual responses to alcohol and the consequent risks and benefits of alcohol to health;
- Developing effective prevention and treatments that address the physical, behavioral, and social risks attributable to excessive and underage alcohol consumption, and the chronic relapsing nature of alcoholism; and
- Improve the acceptance of, and access to, quality care.

Bureau of Justice Statistics (BJS) (www.ojp.usdoj.gov/bjs/)

The Bureau of Justice Statistics (BJS), part of the Office of Justice Programs within the U.S. Department of Justice, is the nation's leading source from criminal justice-related data. BJS collects, analyzes, publishes, and disseminates data on crime, criminal offenders, victims, of crime, and the operation of, and expenditures related to, justice systems at all levels of government. These data are used by federal, state, and local policymakers.

Annually, BJS publishes *Bureau of Justice Statistics Key Crime Statistics at a Glance*, a summary of information and data most recently gathered. This report can be found at www.ojp.usdoj.gov/bjs/glance.htm#Crime.

Federal Bureau of Investigation – Uniform Crime Reports (www.fbi.gov/ucr/ucr.htm)

The Federal Bureau of Investigation's (FBI) Uniform Crime Reporting Program (UCR) collects crime statistics from nearly 17,000 law enforcement agencies across the United States, covering approximately 95% of the population. Data are gathered by state and local agencies and submitted to the FBI. Data related to eight categories of crime are gathered: 1) murder and nonnegligent manslaughter; 2) forcible rape; 3) robbery; 4) aggravated assault; 5) burglary; 6) larceny-theft; 7) motor vehicle theft; and 8) arson.

The primary limitation of UCR is that it measures reported crime rather than all crimes committed. Reported levels may vary from community to community as a result of a wide variety of factors, including funding and aggressiveness of local law enforcement agencies. The FBI operates two other reporting systems. The National Crime Victimization Survey collects data on unreported as well as reported crime by surveying a representative sample of households. The National Incident-Based Reporting Systems presents comprehensive, detailed information about crime incidents to law enforcement, researchers, and planners.



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Centers for Disease Control and Prevention (CDC) (www.cdc.gov)

The federal Centers for Disease Control and Prevention (CDC) is the lead federal agency charged with protecting the health and safety of Americans, providing information for making health decisions, and promoting and protecting the nation's health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control strategies, environmental health approaches, and health promotion and education activities. There are 11 national centers.

National Center for Injury Prevention and Control (NCIPC) (www.cdc.gov/ncipc/)

The National Center for Injury Prevention and Control (NCIPC) works to reduce morbidity, disability, mortality, and costs associated with injuries occurring outside the workplace. One of the federal Centers for Disease Control and Prevention, NCIPC conducts and supports research about causes, risk factors, and preventive measures for injuries outside the workplace, including:

- Unintentional injuries related to falls, fires, drowning, poisoning, motor vehicle crashes (including those involving pedestrians), sports and recreational activities, and playgrounds and day-care settings;
- Intentional injuries related to homicide, suicide, youth violence, intimate partner violence, child maltreatment, and sexual violence; and
- Improving health and quality of life after injuries and preventing secondary conditions among people with disabilities.

NCIPC also funds research by universities and other public and private groups studying the three phases of injury control (prevention, acute care, and rehabilitation) and the two major disciplines of injury control (epidemiology and biomechanics).

HIV/AIDS Surveillance Report (www.cdc.gov/hiv/stats/hasrlink.htm)

The HIV/AIDS Surveillance Report is published annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC. It contains data about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, gender, race/ethnicity, age, vital status, and case definition category.

National Center for HIV, STD, and TB Prevention (NCHSTP) – Division of Sexually Transmitted Diseases (www.cdc.gov/nchstp/od/nchstp.html)

CDC's Division of Sexually Transmitted Diseases (STDs) provides national leadership through research, policy development, and support of effective services to prevent STDs (including HIV infection) and their complications, such as enhanced HIV transmission, infertility, adverse outcomes of pregnancy, and reproductive tract cancers. The Division assists health departments, health care providers, and non-governmental organizations and collaborates with other governmental entities through the development, syntheses, translation, and dissemination of timely, science-based information; the development



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of goals and science-based policy; and the development and support of science-based programs that meet the needs of communities.

National Center for HIV, STD, and TB Prevention (NCHSTP) – Division of Tuberculosis Elimination (www.cdc.gov/nchstp/tb/surv/surv.htm)

The NCHSTP Division of Tuberculosis Elimination (DTBE) seeks to provide leadership in preventing, controlling, and eventually eliminating tuberculosis (TB) in the U.S., in collaboration with partners at the community, state, and international levels. To accomplish this mission, the DTBE carries out the following activities:

- Develops and advocates effective and appropriate TB prevention and control policies;
- Supports a nationwide framework for monitoring TB morbidity and mortality;
- Detects and investigates TB outbreaks;
- Conducts clinical, epidemiological, behavioral, and operational research to enhance TB prevention and control efforts;
- Evaluates prevention effectiveness;
- Provides funding and technical assistance to state and local health departments; and
- Provides training, education, and technical information services to state and local health departments.

DBTE publishes an annual TB Surveillance Report. The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc.)

Behavioral Risk Factor Surveillance System (BRFSS) (<http://www.cdc.gov/brfss>)

CDC's National Center for Chronic Disease Prevention and Health Promotion administers the Behavioral Risk Factor Surveillance System (BRFSS), the world's largest telephone survey. Based on an understanding that personal health behaviors play a major role in premature morbidity and mortality, BRFSS facilitates the collection of behavior-related data on a state-specific basis. State-level surveillance of prevalence of major behavioral risks assists states in planning, initiating, supporting, and evaluating health promotion and disease prevention programs.

National Center for Health Statistics (NCHS) (www.cdc.gov/nchs)

CDC's National Center for Health Statistics (NCHS) provides statistical information to be used by policymakers and health professionals to improve the health of the American people. As the nation's principal health statistics agency, NCHS is responsible for providing accurate, relevant, and timely data. NCHS has two major types of data systems: those based on



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populations, containing data collected through personal interviews or examinations; and those containing data collected from vital and medical records.

National Highway Traffic Safety Administration – Fatality Analysis Reporting System (FARS) (www-fars.nhtsa.dot.gov)

The Fatality Analysis Reporting System (FARS) facilitates the collection and reporting of data for all fatal crashes involving automobiles in the United States, and provides a basis for evaluation of overall highway safety, motor vehicle safety standards, and highway safety initiatives and programs. FARS maintains cooperative agreements with agencies in each state to collect and report fatal crash data in a standard format. Data is available through a web-based “encyclopedia”.



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State Sources

Washington State Department of Social and Health Services, Divisions of Alcohol and Substance Abuse - TARGET

TARGET (Treatment Assessment Report Generation Tool) is a reporting management information system used by the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Reporting is required for treatment agencies providing public sector-contracted/funded treatment services and optional for private pay individuals served. TARGET information collection is based on establishing a baseline at admission to treatment and capturing/identifying changes to that baseline upon discharge, thus providing information on progress during treatment.

Office of Financial Management – Population Trends for Washington State (<http://www.ofm.wa.gov>)

The Office of Financial Management (OFM) provides official population counts and estimates. Population figures reported by OFM include all persons who normally reside in the state, including military personnel and dependants, persons in correctional institutions, residents of nursing care facilities, and college students.

Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, and Research and Data Analysis – Washington Needs Assessment Household Survey (<http://psy.utmb.edu>)

The Washington Needs Assessment Household Survey (WANAHS) was a statewide survey of over 7,000 adults designed to measure the prevalence of substance use and need for treatment. The survey was conducted over a 14-month period from September 1993 through October 1994. The WANAHS sample included large number of minorities and other groups in order to facilitate demographic analysis. Several statewide and county-level profiles have been prepared based on WANAHS, the most recent being *Profile of Substance Use and Need for Treatment in Washington State* (1999).

Washington State Department of Health – Center for Health Statistics (<http://www.doh.wa.gov/>)

Data used come from Certificates of Live Birth, Fetal Death, Death, Marriage, and Dissolution. Data for Washington State Vital Statistics are compiled for each year from certificates received before April 15 of the following year.

Washington State Department of Health, Office of Hospital and Patient Data System – Comprehensive Hospital Abstract Reporting System

The Washington State Department of Health's Comprehensive Abstract Reporting System (CHARS) monitors hospital admission trends, causes of hospitalization, and other indices used to evaluate the quality and accessibility of health care in Washington. Key data elements include patients' age, sex, physician, primary and secondary diagnoses, principal and secondary procedures, length of stay, and discharge status.



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CHARS does not include data from federal, military and Veteran's Administration hospitals. Also excluded from the system are emergency room visits, data from outpatient facilities, surgery centers, birthing centers, and free-standing mental health, substance abuse, and rehabilitation centers or clinics.

Washington Traffic Safety Commission (<http://www.wa.gov/wtsc/index.htm>)

Collaboration among state, federal, and local partners is key in designing and implementing successful traffic safety programs. Each year the federal government allocates part of the federal Highway Trust Fund to the states to carry out highway safety programs. The Washington Traffic Safety Commission (WTSC) has administered these funds and facilitates these efforts in Washington State since 1967. Governor Gary Locke serves as WTSC chair. WTSC offers several programs, including the following: Impaired Driving, Community DUI & Traffic Safety Programs, Occupant Protection, Police, Traffic Records and Research, Youth, College-Age, Pedestrian/Bicycle, and Public Information and Education.

Washington State Survey of Adolescent Health Behaviors.

The Washington State Survey of Adolescent Health Behaviors (WSSAHB) provides information about the health attitudes and behaviors of Washington youth. A student survey has been conducted in Washington in even-numbered years since 1988, under the auspices of the Office of Superintendent of Public Instruction (OSPI). The WSSAHB includes a sample of public schools students in 6th, 8th, 10th, and 12th grades. The survey provides information on tobacco, alcohol and other drug use, violence, related risk and protective factors, and demographics (age, race, and gender).

Survey samples are selected using a stratified cluster sampling procedure, with schools being the primary sampling unit. Data from student surveys are useful for obtaining statewide estimates of the prevalence of health risk behaviors among youth, examining trends and patterns in risk behaviors, and establishing profiles of persons at risk. Caveats related to the data include:

- Students survey does not represent youth who have dropped out of school. It is thought to be likely that these youth are the most likely to engage in high-risk behavior.
- Health risk behaviors may be underestimated as it is self-reported. Willingness to self-report behavior is subject to social acceptability norms.
- Changes in time of year for survey administration means that students may differ in age and experience from survey to survey, and seasonality factors may affect results. In such instances (as in 2002), data may not be comparable with previous surveys or with national surveys conducted at a different time of year.

